STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING ______ B. WING ______	C 03/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to maintain dignity and quality of life for 1 of 7 sampled residents by failing to provide complete and timely ileostomy replacement (Resident # 2). The findings include: Review of Resident # 2's record revealed she was admitted to the facility on 7/18/16 with diagnoses including Acute Hematogenous Osteomyelitis, Myasthenia Gravis, Unspecified Open Wound lower leg, Hypertension, Diabetes Mellitus, History of Cancer, Depression and Anxiety. The most recent Quarterly MDS dated 2/20/17 assessed Resident # 2 as having no cognitive or memory deficits. She was also assessed as having no behaviors and as needing extensive assistance from 1 staff for bathing and hygiene. Review of Resident # 2's current care plan dated 2/11/17 and updated on 3/2/17 revealed a problem area of "has potential/actual elimination deficit related to Ileostomy with a goal of "will have dignity maintained with staff assistance for toileting needs and will remain clean and dry with staff intervention." Interventions included "Ileostomy care every shift, provide staff	F 241	1. Resident #2 received ileostomy care by the 1st shift charge nurse on 2/13/17 and trash was removed from the resident room and discarded. The Licensed nurse assigned to Resident #2 during 3rd shift on 2/12/17 was provided with 1:1 education on Dignity and Respect and proper disposal of colostomy soiled equipment and time management in changing an ostomy product to meet the needs of resident by the Director of Nursing on 3/24/17. 2. Residents requiring assistance with ostomy care have the potential to be affected by this alleged practice. Current residents with ostomies have been interviewed by the social worker to assure ostomy care is provided with Dignity and Respect. Opportunities were corrected as identified. 3. All Nursing personnel will be re-educated by the Administrator, DON or Nurse Managers on Dignity and Respect with regards to ostomy care and maintenance. This re-education will be completed by April 12, 2017. Dignity and Respect is also given in orientation of new	4/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/10/2017

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 241	Continued From page 1 assistance as required for toileting and staff to teach ileostomy self-care." Further record review revealed Resident # 2 used an indwelling catheter and an ileostomy due to a ruptured bowel during removal of Colonic Adenocarcinoma. She was hospitalized on 2/3/17 with cellulitis and readmitted to the facility on 2/11/17. Review of ileostomy care documentation revealed the ileostomy bag was ordered to be changed every 5 days and was documented as changed on 2/13, 2/19 and 2/24/17. Nursing notes for February 2017 noted nothing significant with her ileostomy care. Review of grievances for 2017 revealed no concerns voiced by Resident # 2 regarding her care. Observations of Resident # 2 on 3/22/17 at 10:00 AM revealed she was resting in bed on an air bed with a sheet folded under her back. She was observed to have a Foley catheter in place and had casts below the knee on both legs. Interview with Resident # 2 on 3/22/17 at 10:00 AM revealed she was aware when her ileostomy bag needing emptying and rang her call bell for assistance. She reported care was typically provided within 15 minutes and her entire ileostomy was changed by nursing staff every 5 days in a timely manner except for on 2/12/17 as follows: "Nights are worse, one night the bag, entire bag popped off around 5:30 [AM] and a nurse [name given] said she was too busy to assist me because she was giving meds. The bag spewed everywhere, and that can happen because I have gas. She just wiped me off, put the bag in the trash, put a towel by my side and left. The bag smelled really bad in the room. The	F 241	hires by the Staff Development Nurse and Human Resources Director. DON or Nurse Managers will monitor the appropriate care and changing of ostomy products, by interviewing two residents requiring care and maintenance of their ostomy by presenting a questionnaire two times a week x 12 weeks. 4. The Director of Nursing will report the results of these audits to the QAPI committee monthly and recommendations will be made as required. 5. 4/12/17	

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next morning early I told the CNA [certified nursing assistant] and she got the nurse to replace the bag, but that wasn't until the morning when 1st shift came in."

Further interview with Resident # 2 on 3/23/17 at 9:15 AM revealed the nurse involved had cared for her since 2/12/17 and had been kind and provided care as needed, but reported "it was not good that night; I was scared, anxious and uncomfortable. I reported it to the former administrator and he said he would take care of it and it would not happen again and it hasn't, but it was bad that night. I was afraid I would have gas again and stool would come out all over the bed."

Interview on 3/22/17 at 3:17 PM with the identified nurse who cared for Resident # 2 on 2/12/17 confirmed the incident occurred. She reported 2/12/17 was a busy night and stated "Another resident was having an issue and I was just starting to pass medications [Resident # 2] put her call light on and said her colostomy bag had ruptured on her and the bed. I had to put a towel on it and told her I would be back as I had to get supplies and was not sure where to locate those. I cleaned her with wipes, put a towel on the site, emptied the bag in the toilet and put it in the trash. Then I went and gave my meds, which I finished around 7 AM. A 1st shift CNA came and got me and I changed the colostomy at that time. She (the CNA) acted upset with me, like I shouldn't have left her like that, but I had to give my medications." When asked by the surveyor how long Resident # 2 had to wait with no colostomy in place, the nurse initially reported "15 - 20 minutes," but when asked further she reported the request for assistance was made when she initially started her medication pass,

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which was typically at 5:30 - 5:45 AM, so the resident could have waited for an hour or more. When asked if facility management had talked with her about the incident or any corrective actions had been put in place to prevent Resident # 2 from waiting so long if her ileostomy bag had to be changed on 3rd shift, she reported no one had talked with her about the incident and she was not aware of any corrective actions put in place.

Interview on 3/23/17 with the 3rd shift CNA who was assigned to work with Resident # 2 on 2/12/17 revealed she could not remember any specifics regarding Resident # 2's ileostomy care, other than nursing staff replaced the bag and CNA's ensured the bags were emptied. The CNA could not recall the incident on 2/12/17.

Interview on 3/23/17 at 9:55 AM with the CNA who was working with Resident # 2 on the morning of 2/13 revealed she checked on Resident # 2 at the beginning of her shift on 2/13/17 around 7:15 and noticed a strong odor of feces. The CNA reported "she was lying in bed and was dosing off, but reported her ileostomy bag was gone and she needed a new one; she was upset and said she had been laying without one for a while." The CNA further reported the resident had been cleaned up and a towel was lying beside the ileostomy site. The CNA reported she found the 3rd shift nurse, assisted her with finding the colostomy replacement and ensured the resident was provided the replacement. The CNA reported "we empty the bag, but a nurse has to replace them and the nurse reported she got busy and did not have time to replace it due to giving medications."

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F 241	Continued From page 4 Interview on 3/23/17 at 1:40 PM with the Unit Manager RN revealed she was not aware of the incident that occurred on 2/12/17 and that nurses or a trained NA could replace ileostomy bag as needed, but nurses typically replaced bags every 5 days and as needed. Interview on 3/23/17 at 2:10 pm with the current Director of Nursing (DON) revealed she spoke with the involved nurse on 3/22/17, who reported she was busy giving medications on 2/12/17 and asked the CNA on the hall to ensure Resident # 2 was cleaned up and to seek the supplies needed. The DON further reported it appeared the 3rd shift CNA did not follow through. Interview on 3/23/17 at 2 pm with the current Administrator, who had been in the position since 3/16/17, but was the Director of Nursing from October 2016 until 3/16/17, revealed she was not aware of Resident # 2 waiting for an extended time for ileostomy care, so no corrective actions had been put in place. The Administrator further reported typically when an incident or concern was reported, the incident would be documented, management would review the incident, put corrective measures in place and monitor to ensure it did not re-occur; The Administrator further reported 3rd shift has less nursing staff scheduled, and the changing of a colostomy bag may be delegated to a CNA, if the CNA had been trained to change the ileostomy. The Administrator acknowledged waiting for an extended period of time without ileostomy care was a dignity issue.	F 241		