STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345169	A. BUILDING: _____ B. WING _____	8/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	969 COX ROAD GASTONIA, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for

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any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews the facility failed to ensure the grievance resolutions were provided in writing to 2 of 3 sampled residents (Resident #3 and Resident #9).

The findings included:

1. A review of Resident #3's admission Minimum Data Set (MDS) dated 07/14/17 revealed he was cognitively intact for daily decision making.

A review of a facility document titled "Concern Form" filed by Resident #3 and dated 08/03/17 revealed in the section labeled Description of Concern that Resident #3 reported a silver colored necklace missing and that he did not feel like the necklace was stolen but that he could have misplaced it. The Concern Form had no explanation under the Action Taken section. The concern form was signed by the Social Service Assistant (SSA) on 08/03/17 which indicated the concern had been investigated and signed and dated by the Administrator on 08/03/17 as well. There was no indication on the form that a written summary of the investigation and resolution had been given to Resident #3.

An interview with the SSA on 08/23/17 at 10:03 AM revealed she was given Resident #3's concern form to investigate. The SSA explained she saw Resident #3 in the hallway and went to talk with him about the necklace. The SSA stated Resident #3 became upset and told her that he did not care about the necklace and told her to drop it then refused to talk with her anymore about it. The SSA then stated she gave the form to the Administrator.

An interview with the Administrator on 08/23/17 at 4:47 PM revealed she was the facility's Grievance Official and she understood the new grievance regulation was to ensure the complainant/complainants were given a written copy of the investigation and resolution only upon request.

2. A review of Resident #9's quarterly Minimum Data Set (MDS) dated 08/18/17 revealed he had moderately impaired skills for daily decision making and could make himself understood as well as could understand others.

A review of a facility document titled "Concern Form" filed by Resident #9 and dated 8/17/17 revealed in the section labeled Description of Concern that Resident #9 reported in part that he had three dollars missing and had checked everywhere in his room for it and knew he had not spent it. Under the section titled Action Taken it was written in part that Resident #9's room was searched and the three dollars was found behind the dresser in his room. The form was signed and dated by the Administrator on 08/17/17. There was no indication on the form that a written summary of the investigation and resolution had been given to Resident #9.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	Continued From Page 2 An interview with the Administrator on 08/23/17 at 4:47 PM revealed she was the facility's Grievance Official and she understood the new grievance regulation was to ensure the complainant/complainants were given a written copy of the investigation and resolution only upon request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		9/8/17

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

Electronically Signed | 09/01/2017

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 280	Continued From page 1 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

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F 280	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record reviews and Responsible Party and staff interviews the facility failed to ensure the Resident and/or the Responsible Party was invited to attend the Care Plan meeting for 1 of 5 residents (Resident #3) reviewed for notification of participation in Care Plan meetings. The findings included: Review of Resident #3's medical record revealed he was admitted to the facility on 07/07/17 with diagnosis that included diabetes mellitus, and a right tibia and fibula fracture. Resident #3's admission Minimum Data Set (MDS) dated 07/14/17 indicated that he was cognitively intact and could make his needs known. During a telephone conversation on 08/22/17 at 12:52 PM Resident #3's Responsible Party stated the facility had not contacted her to have a family consultation about Resident #3's care. The Responsible Party stated she would need to make arrangements for Resident #3's care after his discharge and she had not heard anything from the facility. Review of Resident #3's medical record from admission date of 07/07/17 to 08/23/17 revealed no documentation of Care Plan meeting notes or that Resident #3 or his Responsible Party had been invited to a Care Plan meeting. On 08/23/17 at 6:00 PM during an interview with the Social Service Manager (SSM) she stated she was responsible for the Care Conferences for	F 280	Unable to schedule a care plan meeting for Resident #3, as Resident #3 has been discharged from facility. Social Service Manager inadvertently overlooked scheduling a Care Plan Meeting for Resident #3; Human error. Scheduling of each Care Plan Meeting will be included in the Admission Checklist to ensure that a Care Plan Meeting is scheduled for each Admission. All Residents identified as having potential to be affected. Audit of all current Residents admitted in the last 30 days conducted by Social Service Director to identify any other Resident and/or Responsible Party who has not been invited/notified to participate in Care Plan Meeting. Education provided by Administrator to the Interdisciplinary Care Plan Team (including DON, MDS RN, Rehabilitation Director, Social Service Director, Dietary Manager, and Activities Director) to ensure understanding of Resident and/or Responsible Party notification and participation in Care Plan Meeting. Care Plan Meeting Notification/Participation Monitoring Tool implemented to ensure notification and participation in Care Plan Meeting for Resident and/or Responsible Party, and the date that each Care Plan Meeting is	

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F 280	Continued From page 3 the residents who were admitted for short term stay. The SSM explained the process of how she kept up with scheduling the Care Conferences was that the Residents' were given about 72 hours for the Therapies to evaluate and develop goals for them then when they discuss the Residents' in the morning meeting it was a trigger for her to set up the Resident's Care Conference with the Resident and or their Responsible Party. The SSM stated Resident #3 was admitted for short term stay but he did not work with Therapies at first because he had an order for no weight bearing on his right foot. The SSM further stated that Resident #3 moved to 100 hall (long term hall) shortly after he was admitted and she missed scheduling him for the Care Conference. During an interview with the Administrator on 08/23/17 at 6:27 PM she stated it was her expectation for the Social Workers to plan and involve the Residents and/or their Responsible Party in their Care Conferences.	F 280	scheduled. Care Plan Meeting Notification/Participation Monitoring Tool to be completed by Administrator once weekly for 12 weeks to ensure a Care Plan Meeting has been scheduled and notification and participation for the Resident and/or Responsible Party. Administrator is responsible for implementing the Plan of Correction. Care Plan Meeting Notification/Participation Monitoring Tool incorporated into monthly Quality Assurance and Performance Improvement Meeting to ensure compliance and evaluate effectiveness.	