STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 12/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	**1086 MAIN STREET NORTH YANCEYVILLE, NC 27379**

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/19/18

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

Electronically Signed | 12/19/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a care plan for 1 of 1 sampled residents with behaviors when providing activity of daily living assistance (ADL). (Resident #1). Findings Included: Resident #1 was admitted on 10/8/18 with diagnosis of vascular dementia with behavioral disturbance. The most recent admission Minimum Data Set (MDS) assessment dated 10/15/18 revealed she was severely cognitively impaired. She required assistance with toileting, hygiene and bathing. She had behaviors towards others 4-6 days in the assessment period. Record review of the Resident #1 care card revealed, Special Instructions: "Two staff member with ADL Care. Alert nurse if resident is extremely agitated. Allow resident to calm. Provide nonstimulating environment, Provide 1 on 1 activities allow resident to refuse care alert nurse to refusal. " Record review revealed Resident #1 had no care plan for behaviors during ADL care. On 12/3/18 at 8:00AM, Unit Manager #1, indicated that the nurse or Interdisciplinary Team (IDT) did the care plans. Resident #1 should have had a care plan about behaviors, because she required assistance and was combative. Observation on 12/3/18 at 9:06AM, revealed Resident #1 refused assistance for incontinent care and refused to wear a brief for incontinence. Staff reapproached resident several times to provide incontinent care. Resident #1 agreed to care and then pulled away and postured during	F 656	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 656 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of current residents care plans who exhibit behaviors during ADL care to ensure all risks are identified on the Behavior Management care plan per the Resident Assessment Instrument manual guidelines. Resident #1 was identified as not having a care plan that addressed behaviors during ADL care. The Behavior Management care plan was developed by the Resident Care Management Director. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in the implementation of care plans according to the RAI Manual on December 17, 2018. The RCMD will	

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F 656	Continued From page 2 each approach. During interview on 12/3/18 at 9: 08 AM ,Aide #1 indicated that Resident #1 refused any assistance with ADL's. Staff were to report refusals to the nurse and left Resident #1 alone. During interview on 12/4/18 at 9:12AM, Nurse #4 indicated that the IDT completed the care plans. During a telephone interview on 12/4/18 at 12:45 PM, Nurse #5 indicated the nurses did not do the care plans, the MDS did the care plans. On 12/4/18 at 1:16PM,MDS Nurse #1 indicated the initial care plan was done by the floor nurse. Residents who resisted care were discussed in morning meeting. Social services care planned the behaviors. During 12/4/18 at 2:00 PM, interview with MDS Nurse #2 revealed that the nurses did the base line care plan and MDS does the first care plan. The social services department did behavior portion of the care plan. We were aware that the social services area was a weak area. The social worker was not available for interview. During an interview on 12/4/18 at 3:38 PM, Unit Manager #2 indicated the care plan was done by the IDT team. The nurses on the floor updated the care plan. The IDT team updated the care plan with the new orders. The social worker or the IDT would address the behavior. During an interview on 12/4/18 at 4:00PM, the Director of Nursing indicated that since November 2018 we became aware that the social worker had not been completing the care plans. She was responsible for the care plans for behavior, she had recently resigned.	F 656	randomly audit five residents care plans, exhibiting behaviors during ADL care, weekly for 12 weeks and then five residents care plans, exhibiting behaviors during ADL care, monthly for an additional 3 months to verify appropriate Behavior Management care plans. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Revisions to the care plans will be completed as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) December 28, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		12/19/18

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F 657	Continued From page 3 §483.21(b)(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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and revise care plans for 2 of 3 residents who were receiving enteral feedings through a feeding tube. (Resident #6 and # 2). Findings Included: 1. Resident # 6 was admitted on 4/27/16 with diagnoses in part: pneumonia, dementia, traumatic brain injury gastrointestinal bleed.	F 657	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 657 1. The plan of correcting the specific deficiency. The plan should address the	

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F 657	Continued From page 4 Minimal Data Set (MDS) dated 10/2/18 modification of quarterly assessment: Resident is cognitively severely impaired. Resident requires total assistance with all activities of daily living with 1-2 people. Care plan revealed: The Resident requires tube feeding via Peg tube related to Dysphagia; Barretts Esophagus, Depression, Hemiplegia, Dementia. Nothing by mouth: Enteral Nutrition Jevity 1.5 @ 90ml/hr. x 16hrs. Flushes 200 cc every 4 hours. Resident will remain free of adverse effects or complications related to tube feeding; adequate nutrition to maintain body weight. Interventions: Check for tube placement and gastric contents/residual volume per facility protocol and record. Elevate head of bed 30-45 degrees (semi-fowler's position) during feedings and at least 1 hour after feeding to prevent aspiration/pneumonia. Provide local care to Peg tube site as ordered and observe for sign and symptoms of infection. Registered dietitian to evaluate. Dated quarterly and as needed. Observe caloric intake, estimate needs. Make recommendations for changes to tube feeding and needed. See physician orders for current feeding orders. initiated 3/7/17, revision on 12/4/18. Physician order dated 11/28/18 Enteral Feeding: Enteral Feeding: Jevity 1.5 to run at 72 mLs per hour with a four-hour break. Amount to be infused: 7-3 288 mLs. Amount to be infused: 3-11 576 mLs. On 12/4/18 @ 3:00 pm an interview was conducted with LPN #1 and she stated that the	F 657	process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of current residents care plans receiving enteral feeding to ensure all risks are identified on an enteral feeding care plan per the Resident Assessment Instrument manual guidelines. Resident #6 was identified as not having an accurate Enteral Feeding care plan. The Enteral Feeding care plan was corrected by the Resident Care Management Director or designee. Resident #2 was identified as not having an accurate Enteral Feeding care plan. The Enteral Feeding care plan was corrected by the Resident Care Management Director or designee. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in the implementation of care plans according to the RAI Manual on December 17, 2018. The RCMD will randomly audit five residents care plans who are receiving Enteral Feeding, weekly for 12 weeks and then five residents care plans who are receiving Enteral Feeding, monthly for an additional 3 months to verify appropriate Enteral Feeding care plans. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Revisions to the care plans will be completed as needed. 3. The monitoring procedure to ensure	

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F 657	Continued From page 5 resident's current tube feeding order was for Jevity 1.5 cal to be ran at 72 mL/hour according to the Medication Administration Record 2. Resident # 2 was admitted on 7/13/18 with diagnoses in part of dysphasia due to cerebral infarction. The most recent Minimum Data Set (MDS) dated 10/14/18 revealed severe cognitive impairment and tube feeding with a mechanically altered diet. Record review of the most recent physician order dated 11/2/18, revealed, Enteral feeding, Glucerna 1.2 via pump at 60 cubic centimeters per hour to run (infuse) for 12 hours. Start at 7:00 PM and stop at 7:00 AM. Review of the most recent feeding tube care plan was dated 7/25/18 with Jevity 1.5 at (infusing) 85 milliliters per hour for 16 hours. Water flushes 150cc every 4 hours. During an interview on 12/3/18 at 8:00 AM, Unit Manager #1 revealed that the MDS nurse or the interdisciplinary team (IDT) team created and revised the care plan. During an interview on 12/3/18 at 12:45PM, via telephone Nurse # 5 indicated the MDS nurses did the care plans. Changes were reported to the MDS nurses. During interview on 12/4/18 at 8:59AM, Nurse # 6 indicated that the tube feeding care plan was revised when the physician's order for the tube feeding changed. She was not sure who made the revisions. During an interview on 12/4/18 at 9:12 AM, Nurse # 4 indicated that the IDT created and revised the care plans. If a change needed to be made it was reported to the unit manager who reported to the IDT. During interview on 12/4/18 at 1:16 PM, MDS Nurse #1 indicated the IDT team made the revision to the care plans during the morning	F 657	that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) December 28, 2018	

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F 657	Continued From page 6 meeting. During an interview on 12/4/18 at 2:00PM, MDS Nurse #2 indicated the nurses created the baseline care plan and the MDS nurse completed the first care plan in 21 days. During an interview on 12/4/18 at 3:38 PM, Unit Manager #2 indicated the IDT team updated the care plans with the new orders. During an interview on 12/4/18 at 4:04PM, Director of Nursing indicated the expectation was the care plans to reflect the most recent physician orders.	F 657		