STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING ______ B. WING ______	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	**218 LAUREL CREEK COURT SPRUCE PINE, NC 28777**

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/24/19 through 03/28/19. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID# ZSJH11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of this complaint investigation. Event ID#ZSJH11.	F 000		
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	F 656		4/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/19/2019

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 656	Continued From page 1 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 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 observations, record reviews and staff interventions the facility failed to follow a care plan by not applying a left palm protector for 1 of 1 resident reviewed for range of motion (Resident #52). The findings included: Resident #52 was admitted to the facility on 05/10/13 with diagnoses which included cerebral vascular accident and hemiplegia. Review of Resident #52's Care Plan dated 07/03/18 indicated a potential for skin breakdown related to contractures of bilateral upper extremities. The interventions included applying a left palm protector. Review of Resident #52's physician's orders included Palm protector to left hand. Review of Resident #52's recent Minimum Data	F 656	"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 the required by the provisions of federal and state law." Tag F656 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 3/28/19 the Director of Nursing reviewed and revised the Care Plan for Resident #52. b.) Resident #52 was evaluated by Occupational Therapy for contracture	

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F 656 Continued From page 2

Set (MDS) assessment dated 02/10/19 revealed her cognition was moderately intact, she required extensive assistance of 2 staff with most of her activities of daily living and she had functional impairment of one side of both upper and lower extremities (left). The MDS also indicated Resident #52 had not received skilled therapies or restorative nursing for splint or brace assistance during that assessment period.

On 03/26/19 at 3:15 PM an observation was made of Resident #52's left hand which her four fingers were contracted into a fist. Resident #52 stated she could not open her hand or extend her fingers. There was no splint/brace in place for the contractures. Subsequent observations of Resident #52 on 03/27/19 at 8:40 AM, 03/27/19 at 1:33 PM, 03/28/19 at 9:03 AM, and 03/28/19 at 11:02 AM revealed the left palm protector was not in place.

On 03/28/19 at 12:18 PM during an interview with Nurse Aide (NA) #1 she explained that she had been taking care of Resident #52 for about a year and she had never known of her having a palm protector for her left hand. The NA produced a resident assignment sheet which was similar to a mini care plan and stated it was given to the aides to follow. The assignment sheet had no intervention for a splint/brace or palm protector for Resident #52's left hand.

During an interview with Nurse #1 on 03/28/19 at 12:34 PM while reviewing Resident #52's physician's orders she confirmed Resident #52 had an order for a palm protector for her left hand and stated "I'm guessing it should be in place."

On 03/28/19 at 3:14 PM Occupational Therapist

F 656

management and is currently receiving Occupational Therapy and has received a new Palm Protector plan of care was revised accordingly.

2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
a.) All Care Plans for residents with splints and contractures were reviewed by the Care Management MDS Director/Designee and CNA assignment sheets were updated.

3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:

a.) The Care Management MDS Director/designee will audit all residents with splints/braces to ensure they are addressed on the care plan and the CNA assignment sheets are updated weekly x 4 weeks, bi- weekly x4 then monthly x 2 months.
b.) The Case Management MDS Director will review results of the random audits and those findings will be reported at the monthly QAPI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance.

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F 656	Continued From page 3 (OT) in room to evaluate Resident #52's left hand contracture. The OT explained that she worked with Resident #52 about 2 months ago to apply a cup extension to her bedside. The OT stated that Resident #52's left hand looked more contracted now than it did the 2 months prior and that her hand should have something in it at all times because of how badly contracted her left hand was. On 03/28/19 at 5:22 PM during an interview with the Director of Nursing she stated she would have expected the nursing staff or therapy staff to have noticed that Resident #52 did not have a palm protector in her left hand as much as they worked with her and the bottom line was that she should have had something in her hand. An interview was conducted with the Administrator on 03/28/19 at 6:33 PM in which the Administrator stated her expectation was that the staff follow Resident #52's care plan for the application of her left palm protector.	F 656	4.) The title of the person responsible for implementing the acceptable plan of correction: a.) The Care Management MDS Director will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: ¿¿¿¿¿¿¿¿__4/25/19_______ "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 the required by the provisions of federal and state law."	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		4/25/19

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F 688 Continued From page 4 **F 688**

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews the facility failed to apply a left palm protector for contracture management for 1 of 1 resident reviewed for range of motion (Resident #52).

The findings included:

Resident #52 was admitted to the facility on 05/10/13 with diagnoses which included cerebral vascular accident and hemiplegia.

Review of Resident #52's Care Plan dated 07/03/18 indicated a potential for skin breakdown related to contractures of bilateral upper extremities. The interventions included applying a left palm protector.

Review of Resident #52's physician's orders included Palm protector to left hand.

Review of Resident #52's recent Minimum Data Set (MDS) assessment dated 02/10/19 revealed her cognition was moderately intact, she required extensive assistance of 2 staff with most of her activities of daily living and she had functional impairment of one side of both upper and lower extremities (left). The MDS also indicated Resident #52 had not received skilled therapies or restorative nursing for splint or brace assistance during that assessment period.

Provider's Plan of Correction:

Tag F688

1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
a.) Resident #52 was re-evaluated on 3/27/19 by a Licensed Occupational Therapist and began receiving Occupational Therapy 5 days weekly. As of this writing (4/18/19) resident #52 continues to receive Occupational Therapy which includes diathermy for pain management, passive range of motion to left hand, and placement of palm protector in left hand.
b.) Occupational Therapist or designee will educate 100% of Nurses and CNA□s on proper placement of palm protector and demonstrate hand hygiene. Occupational Therapy will continue until resident #52 is evaluated by a Licensed Occupational Therapist and is found to no longer benefit from such therapy.

2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited:
a.) 100% of residents will be assessed to identify all residents that have contracture(s). All residents identified to

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F 688

Continued From page 5

On 03/26/19 at 3:15 PM an observation was made of Resident #52's left hand which her four fingers were contracted into a fist. Resident #52 stated she could not open her hand or extend her fingers. There was no splint/brace in place for the contractures. Subsequent observations of Resident #52 on 03/27/19 at 8:40 AM, 03/27/19 at 1:33 PM, 03/28/19 at 9:03 AM, and 03/28/19 at 11:02 AM revealed the left palm protector was not in place.

On 03/28/19 at 12:18 PM during an interview with Nurse Aide (NA) #1 she explained that she had been taking care of Resident #52 for about a year and she had never known of her having a palm protector for her left hand. The NA produced a resident assignment sheet which was similar to a mini care plan and stated it was given to the aides to follow. The assignment sheet had no intervention for a splint/brace or palm protector for Resident #52's left hand.

During an interview with Nurse #1 on 03/28/19 at 12:34 PM while reviewing Resident #52's physician's orders she confirmed Resident #52 had an order for a palm protector for her left hand and stated "I'm guessing it should be in place."

On 03/28/19 at 3:14 PM Occupational Therapist (OT) in room to evaluate Resident #52's left hand contracture. The OT explained that she worked with Resident #52 about 2 months ago to apply a cup extension to her bedside. The OT stated that Resident #52's left hand looked more contracted now than it did the 2 months prior and that her hand should have something in it at all times because of how badly contracted her left hand was.

F 688

have contracture(s) will be referred to therapy for evaluation and/or treatment related to contracture management.

b.) Director of Rehab will implement Contracture Management /positioning log to track resident, issue, type of splint ordered, order and date of order in order to follow up quarterly with screens. Any issues identified during the quarterly screen will result in evaluation

3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:
a). The Rehab Program Manager/designee will audit all residents with splints/braces weekly x 4 weeks, bi-weekly x4 then monthly x 2 months to ensure residents plan of care is being followed for residents who have splint/braces ordered.
b.) The Rehab Program Manager will review results of the audits and those findings will be reported at the monthly QAPI meeting monthly X 2 months then quarterly X 2 until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance.

4.) The title of the person responsible for implementing the acceptable plan of correction:

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F 688	Continued From page 6 On 03/28/19 at 5:22 PM during an interview with the Director of Nursing she stated she would have expected the nursing staff or therapy staff to have noticed that Resident #52 did not have a palm protector in her left hand as much as they worked with her and the bottom line was that she should have had something in her hand. On 03/28/19 at 6:33 PM an interview was conducted with the Administrator who stated she expected the staff to follow the physician's orders and apply Resident #52's palm protector.	F 688	a.) The Rehab Program Manager will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: ¿¿¿¿¿¿¿¿__4/25/19_______ "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 the required by the provisions of federal and state law."	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/25/19

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F 761	Continued From page 7 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to remain in the presence of 1 of 1 resident who was observed to self-medicate without staff present (Resident #61). Resident #61 did not have an order or assessment to self-medicate and the nasal spray for allergy symptoms was left at bedside. The findings included: Resident #61 was admitted to the facility on 02/10/19 with diagnoses which included coronary heart disease and myasthenia gravis (an autoimmune neuromuscular disease). The admission Minimum Data Set (MDS) assessment dated 02/15/19 revealed Resident #61 had moderately impaired cognition and could understand others as well as he could make himself understood. Review of Resident #61's medical record revealed no assessment for self-medication or a physician order to self-medicate. Review of Resident #61's physician's orders included an order for Flonase Suspension, 1 spray in each nostril every 12 hours for allergic rhinitis dated 02/25/19	F 761	Tag F761 1.) The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 3/28/19 the Director of Nursing (DON) validated that the nurse for resident # 61 understood that medications cannot be left at bedside for residents to self-administer. Nurse for resident #61 stated that she forgot to administer the Flonase and also forgot to remove it from resident #61's room, but did not instruct the resident to self administer. The DON completed education with the nurse for resident #61 on the importance of resident observation during medication pass. b.) Resident #61's nurse exited resident's room prior to administering resident's Flonase and left the bottle in the room.. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) On 3/28/19 the Director of Nursing (DON) validated that the nurse for resident #61 understood that medications cannot be left at bedside for resident to	

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Continued From page 8

On 03/28/19 at 8:52 AM Resident #61 was observed sitting in his wheelchair at his bedside trying to remove the cap from a Flonase nasal spray bottle. Resident #61 stated that he had never used the nasal spray by himself and when asked why he had the nasal spray he stated that the nurse brought it in and told him to use it. Resident #61 squirted one spray in each nostril then returned the bottle of Flonase into a prescription bag.

On 03/28/19 at 8:57 AM an interview was conducted with Nurse #1 who was outside Resident #61's door standing at her medication cart. Nurse #1 stated she forgot Resident #61's nasal spray and left it in his room after she gave him his medications. The Nurse explained that she should have administered Resident #61's nasal spray and not left it with him and denied that she instructed him to administer the nasal spray himself. The Nurse confirmed that Resident #61 did not have an order to self-medicate.

Interview with the Director of Nursing on 03/28/19 at 5:38 PM revealed she would have expected Nurse #1 to have administered Resident #61's nasal spray and not left it in his room for him to self-medicate.

During an interview with the Administrator on 03/28/19 at 6:33 PM she stated her expectation was that Nurse #1 had administered Resident #61's nasal spray and not left it in his room for him to self-medicate.

F 761

self-administer. Nurse for resident #61 stated that she forgot to administer the Flonase and also forgot to remove it from resident #61’s room, but did not tell him to self administer. The DON completed education with the nurse for resident #61 on the importance of resident observation during medication pass and not leaving medications at bedside.
b.) On 3/29/19 Licensed Professional Staff were re-educated on Medication Administration in the Nursing Facility with emphasis on resident observation during medication pass and not leaving any medications at the bedside. All Licensed Professional Staff were given education on Medication Management and all Licensed Professional Staff completed the Medication Management Program Test.

3.) The monitoring procedure to ensure the acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance:
a). The DON/designee will document medication pass audits on all Licensed Professional Staff.
b). The DON/designee will document random Med Pass audits to ensure no medications were left at bedside of 3 random residents per week x 4 weeks, 1 resident per week x 4 weeks then monthly for one additional month to ensure compliance is achieved and maintained.
c.) The DON will review results of the random audits and those findings will be reported at the monthly QAPI meeting monthly X 2 months then quarterly X 2

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F 761	Continued From page 9	F 761	until substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services or designee to maintain continued compliance. 4.) The title of the person responsible for implementing the acceptable plan of correction: a.) The DON will be responsible for the implementation of the acceptable plan of correction. 5.) Date when corrective action will be completed: ¬¬¬¬¬¬¬¬¬__4/25/19_______	