BRIAN CTR HLTH & REHAB  BREvard

345208

(11) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

A. BUILDING
B. WING

(13) DATE SURVEY
COMPLETED

02/16/2012

STREET ADDRESS, CITY, STATE, ZIP CODE
115 N COUNTRY CLUB RD
BREvard, NC 28712

(14) ID
PREFIX
TAG

403.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident
environment remains as free of accident hazards
as is possible; and each resident receives
adequate supervision anc assistance devices to
prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff
interviews the facility failed to apply a pressure
pad alarm to the wheelchair and a stop sign
bathroom door for one (1) of six (6)
sampled residents with falls. (Resident #4).

The findings are:

Resident #4 was admitted to the facility with
diagnoses including Arthritis, Cerebral Vascular
Accident (CVA/Stroke) with paralysis, Muscle
Atrophy, and abnormal gait. On the annual
Minimum Data Set (MDS), dated 12/02/11,
Resident #4 was assessed as having short and
long term memory problems, moderately
impaired cognition for daily decision making, and
as being continent of bowel and bladder with
extensive assistance with toileting. Resident #4
was also assessed as requiring balance support
with standing and transfers, having impaired
range of motion in the upper and lower
extremities, and mobile via wheelchair. The MDS
further revealed Resident #4 was receiving
anticoagulant and diuretic medications.

Residents affected by the alleged
deficient practice. Unit Manager verified placement of pressure
alarm pad in bed and wheelchair
and stop sign on bathroom door
for Resident #4 on 2/15/12. On
2/15/12, Unit Manager reviewed
and verified that care plan and
assignment sheet for Resident #4
were updated with current
interventions, which include
alarm pressure pad in wheel chair
and bed and stop sign on
bathroom door. Director of
Nursing (DON), Unit Managers
and Staff Development Nurse
(SDC) began in service education
2/16/12, with nursing staff
regarding use of assignment
sheets to assure residents needs
are communicated and safety
equipment is utilized as indicated
on residents care plan.

Current facility residents have the
potential to be affected by the
alleged deficient
Practice. DON, Unit Managers
and SDC performed an audit of
current resident charts beginning

"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."

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Donna Y. Adams  Administrator

TITLe  3/19/12

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 are to be corrected not less than 14
days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is to be submitted for
program participation.

FORM CMS-2587(02-09) Previous Versions Obsolete  Event ID:XYT411  Facility ID: 0228065  If continuation sheet Page 1 of 5

RECEIVED
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BY:
F 323 Continued From page 1
Review of facility accident reports from October 01, 2011 through February 15, 2012 and interdisciplinary post fall documentation in medical records revealed Resident #4 experienced falls on 10/07/11, 10/30/11, and 01/28/12. On 10/07/11 Resident #4 attempted to toilet unassisted, fell, and was found on the bathroom floor with a large bruise on her forehead. A wheelchair pressure pad alarm and stop sign net to the bathroom door were implemented and the plan of care was updated. On 10/30/11 Resident #4 fell from her wheelchair while attempting to retrieve a tissue and was found on the floor with no injuries. A reaching device was implemented and the plan of care was updated. On 01/28/12 Resident #4 slid from her wheelchair to the floor without injuries. A referral was made to physical therapy for positioning/posture and a wheelchair cushion was implemented.

Review of the care plan, updated 12/09/11, revealed Resident #4 was at risk for falls due to mental status, history of previous falls, CVA, and use of narcotic medications. The care plan goal specified that Resident #4 would be free of fall related injuries and included interventions for a reaching device, pressure pad alarm to wheelchair, and a stop sign on bathroom door to remind resident to ask for assistance. Review of the Nursing Assistant (NA) Assignment Sheet, utilized by facility staff to communicate residents’ needs and safety devices revealed Resident #4 was at risk for falls and required a reaching device, pressure pad alarm to wheelchair, and stop sign on bathroom door for safety.

On 02/14/12 at 11:45 AM Resident #4 was
<table>
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<tr>
<th>ID PREFIX TAG</th>
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<tr>
<td>F 323</td>
<td>Continued From page 2 observed in the dining room without a pressure pad alarm in her wheelchair. On 02/14/12 at 3:05 PM and 02/15/12 at 08:20 AM, 09:15 AM, and 1:30 PM Resident #4 was observed in her room with no pressure pad alarm in her wheelchair and no stop sign on the bathroom door. During an interview, 02/15/12 at 2:25 PM, Nursing Assistant (NA) #1 stated residents' needs and safety devices were communicated via the NA Assignment Sheet. The interview revealed NA staff were responsible for providing care and interventions as noted on the NA Assignment Sheet. Additional observations on 02/15/12 at 3:30 PM and 5:00 PM revealed Resident #4 seated in her wheelchair without a pressure pad alarm and with no stop sign on the bathroom door in her room. On 02/15/12 at 5:00 PM the Unit Manager (UM) and NA #1 (assigned to Resident #4) observed the resident and confirmed that the pressure pad alarm was not on the resident's wheelchair and a stop sign was not present on the bathroom door. The UM stated NA staff were responsible for reviewing the NA Assignment Sheet at the start of their shift and verifying that safety devices were in place during care rounds. During a follow-up interview on 02/15/12 at 5:05 PM, NA #1 stated she did not review the NA Assignment Sheet at the start of the shift and did not check Resident #4 to ensure the pad alarm and stop sign were in place. On 02/16/12 at 9:30 AM an interview was completed with NA #2 who was assigned to</td>
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<td>F 323</td>
<td>Systemic Changes: DON, Unit Managers, SDC began in service education 2/15/12 for nursing staff with completion of in service on 3/12/12, regarding “Accident Prevention and supervision; use of assignment sheets for communication of resident needs and devices for safety and validation of use of safety equipment and devices for accident prevention.” In service education will be provided during orientation for newly hired nursing employees. Newly admitted residents are assessed using the Fall Risk assessment to determine risk and appropriate interventions will be initiated at that time, with care plan up dates and assignment sheet up dates. DON and Unit Managers review Incident/Accident reports, telephone orders, 24 hour reports and new admission charts, daily Monday through Friday, during morning meeting to review current interventions and update care plan as necessary with</td>
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F 323

 Resident #4 on 02/14/12. NA #2 stated Resident #4 was at risk for falls and required use of a pressure pad alarm to the wheelchair and a stop sign on the bathroom door to remind the resident to call for assistance with toileting. NA #2 stated she did not recall if she verified that Resident #4's pressure pad alarm and stop sign were in place at the start of her shift or throughout the day on 02/14/12.

On 02/16/12 at 11:35 AM an interview was completed with NA #3 who was assigned to Resident #4 on 02/15/12. NA #3 stated prior to this morning (2/16/12) he was not aware that the NA Assignment Sheet was available for review. NA #3 stated residents' needs were communicated to him verbally and that he did not recall if a pressure pad alarm was in use for Resident #4. The interview further revealed NA #3 was not aware that Resident #4 was to have a stop sign on the bathroom door.

On 02/16/12 at 11:45 AM an interview was completed with Licensed Nurse (LN) #1 who was assigned to Resident #4 on 02/14/12 and 02/15/12. LN #1 reviewed the NA Assignment Sheet and confirmed Resident #4 was at risk for falls and was to have a wheelchair pressure pad alarm and a stop sign on the bathroom door for safety. LN #1 stated she was responsible for monitoring NA staff and placing of safety devices during rounds and medication administration. LN #1 stated she did not recall if she checked to ensure Resident #4's alarm and stop sign were in place on 02/14/12 and 02/15/12.

Interview, 02/16/12 at 2:55 PM, with the facility Administrator and Director of Nursing (DON)

changes. Unit Managers will update assignment sheets daily as changes occur. Changes will be communicated to nursing staff using the assignment sheet. Administrator, DON, and Unit Manager will monitor use of equipment and devices during daily compliance rounds and random observations using the assignment sheets beginning 2/23/12. Discrepancies identified will be corrected immediately.

QAA:
The DON will review data obtained during from the Incident/Accident reports, telephone orders, 24 hours reports and compliance rounds to determine continued compliance. Patterns/trends will be identified and analyzed and reported in Q&A for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 323</td>
<td>Continued From page 4 revealed NA staff were responsible for reviewing the NA Assignment Sheets and putting specified interventions in place. The interview further revealed LN staff were responsible for monitoring NA staff and ensuring that safety devices were in place.</td>
<td>F 323</td>
<td>interventions as needed to assure continued compliance.</td>
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