STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 02/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB RD BREVARD, NC 28712

(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 323 SS=D	483.25(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 and 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 net to the 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.	F 323	F 323 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 on 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."**	3/12/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna J. Adams — TITLE: Administrator — (X6) DATE: 3/9/12

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 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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BY:

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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	F 323	2/15/12, to identify residents with safety equipment and devices. Care plans and assignment sheets were reviewed beginning 2/15/12 and completed on 2/23/12, to assure care plans were updated with safety interventions/devices and assignment sheets were accurate with interventions and resident needs for communication to staff. Administrator, DON, Unit Managers and SDC made compliance rounds beginning 2/24/12, throughout facility using assignment sheet to validate use of safety equipment and devices. DON, Unit Managers and SDC began in service education on2/15/12 and will be completed on 3/12/12 for nursing staff, regarding "Accident Prevention and supervision; regarding 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." Nursing Staff that are "PRN" and "LOA" will not work until they have received in service education.. **" 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."**	

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F 323	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	F 323	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 **" 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."**	

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F 323	Continued From page 3 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 placement 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)	F 323	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 QA&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 **" 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."**	

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F 323	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.	F 323	interventions as needed to assure continued compliance. **" 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."**	