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 03/26/2012

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure residents were treated with dignity by feeding one (1) of fifteen (15) sampled residents (Resident # 8) while resident was soiled with urine; by transporting one (1) of one resident observed being transported from the shower room with breasts visible through thin, faded gown and not correcting the problem when brought to the attention of staff (Resident # 3). The deficient practice affected two (2) of eight (8) sampled residents. (Residents # 3 and # 8). The findings are: 1. Resident # 8 was admitted on 12/22/11 with diagnoses including diabetes mellitus, hypertension and dementia. The most recent assessment, a significant change Minimum Data Set (MDS) dated 12/29/11 indicated Resident # 8 had short term and long term memory problems and severely impaired cognitive skills for daily decision making. The MDS also indicated he was totally dependent on staff for toileting and bathing, was unable to move without staff assistance and was always incontinent of bowel and bladder. Resident # 8 was observed on 3/27/12 at 11:35	F 241	F 241 Residents affected by the alleged deficient practice: NA #1 and NA #2 provided incontinence care to Resident #8 on 3/27/12. Resident #3 was changed into another gown on 3/27/12 at approximately 5:10pm. Director of Nursing (DON) Unit Mangers and Staff Development Coordinator (SDC) began in service education for staff, including hospice staff on 3/27/12 regarding resident rights and dignity: providing incontinence care prior to meals and dressing residents in appropriate clothing. Current facility residents have the potential to be affected by the alleged deficient practice. DON, Unit Mangers and SDC began in service education on 3/27/12 for facility staff and Hospice staff that provide care at the facility, regarding dignity/resident rights: Providing care and providing privacy to promote dignity and respect for **" 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."**	4-16-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna J Adams — TITLE: Administrator — (X6) DATE: 4-12-12

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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F 241	Continued From page 1 AM sitting in the hall in a wheelchair wearing light gray sweatpants which were visibly wet in the left groin area. Resident # 8 was observed at 12:30 PM sitting in his room in a wheelchair with a towel draped over his chest and lap which was not draped over him at the time of the earlier observation. He was still dressed in the light gray sweatpants which were visibly wet in the left groin area, which was not covered by the towel. An odor of urine was present in the room. At 12:40 PM Nursing Assistant (NA # 1) took the resident's lunch tray into the room, placed it on the overbed table, pulled the overbed table adjacent to the resident and proceeded to feed him while he was still wearing the wet sweatpants. An interview with NA # 1 on 3/27/12 at 12:55 PM revealed that Resident # 8 was last provided incontinence care about 10:30 AM. NA # 1 looked at Resident # 8's pants and confirmed they were wet with urine. NA # 1 stated she didn't notice he was wet before feeding him. NA # 1 stated they were supposed to check residents for incontinence before lunch. NA # 1 further stated: " I 'm not making excuses but I 'm the only NA on the hall and that makes it hard. I hate to say it but things like this happen." On 3/27/12 at 1:05 PM NA # 1 and NA # 2 were observed providing incontinence care to Resident # 8. The pants smelled of urine and the incontinence brief was wet with urine and smears of feces. An interview with the Director of Nursing (DON) on 3/27/12 at 4:45 PM revealed her expectation is for residents who are incontinent to be changed before being fed. She further stated she would	F 241	the resident. Housekeeping supervisor and laundry staff did an audit of linen to identify threadbare linen. Linens found to be threadbare were removed from the facility. DON and Unit Managers made rounds on units on 3/27/12 to observe and identify residents for appropriate clothing and care. Concerns identified were corrected. Systemic Changes: DON, Unit Manger and SDC began in service education on 3/27/12 for facility staff and Hospice staff that provide care at the facility regarding dignity/resident rights: Providing care and providing privacy to promote dignity and respect for the resident SDC will review resident rights and dignity during orientation for new hires and new Hospice staff and at least quarterly or as necessary for facility staff and current Hospice staff. Housekeeping supervisor began in service education on 3/27/12 for laundry staff regarding **" 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 241	Continued From page 2 expect staff to notice visible signs of incontinence. 2. Resident # 3 was admitted on 4/1/10 with diagnoses including diabetes mellitus, hypertension, anxiety and depression. The most recent assessment, a significant change Minimum Data Set (MDS) dated 1/25/12 indicated Resident # 3 had short term and long term memory problems and severely impaired cognitive skills for daily decision making. The MDS also indicated she was dependent on staff for all activities of daily living (ADLs). Resident # 3 was observed on 3/27/12 at 12:35 PM in a shower chair being pushed down the hall from the shower room past the nurse's station to her room by NA # 3. NA # 3 moved Resident # 3 approximately 30 feet down the hall past several staff members and other residents sitting in wheelchairs. Resident # 3 was dressed in a threadbare, institutional-style gown and both breasts were clearly visible through the gown because the print on the gown was so faded. There was not a blanket or sheet draped over Resident # 3. At 1:00 PM a registered nurse was observed feeding Resident # 3 lunch in her room. Resident # 3 was wearing the same threadbare gown. At 1:12 PM the licensed nurse working with Resident # 3 placed arm protectors on both arms. Resident # 3 was wearing the same thin, faded gown. At 5:10 PM Resident # 3 was observed in her room wearing the same threadbare gown. In an interview on 3/27/12 at 12:37 PM, NA # 3 stated she didn't notice the gown was so thin until	F 241	monitoring and removing threadbare linens from use. Administrator/DON/Unit Managers/RN supervisors and Department managers will conduct compliance rounds daily to monitor for provision of care, appropriate dress and provision of privacy for residents to assure resident dignity and respect. Concerns identified during rounds will be addressed at that time and appropriate interventions will be initiated. Administrator and DON will review concern reports daily Monday through Friday during morning meeting to monitor for dignity and/or respect concerns. The Administrator and/or DON when identified will address concerns. Housekeeping supervisor will conduct linen audits twice a week x 4 weeks then weekly to monitor condition of linen. QAA: The DON and or Administrator will review data obtained during compliance rounds, concern **" 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 241	Continued From page 3 she put it on Resident # 3 after her shower and didn't feel like she could leave her to go get another gown. She could offer no explanation as to why visual privacy wasn't provided to the resident with a towel or blanket. An interview with the DON on 3/27/12 at 4:45 PM revealed she expected residents to be covered with a bath blanket or sheet when being transported from the shower to their room to ensure their body was not exposed. At 5:10 PM the DON observed the threadbare gown on Resident #3 and stated staff should not have placed the gown on Resident #3 when they saw how threadbare it was. No explanation was provided why other staff did not change the resident's gown when care was provided at 1:00 and 1:12 PM.	F 241	audits and linen audits 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 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."**	