STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVE PLACE NW HICKORY, NC 28601

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews the facility failed to implement a tab alert (as identified in the care plan) to prevent falls for 1 of 5 sampled residents. (Resident #3) The findings are: Resident # 3 was originally admitted to the facility 5/21/08 with diagnoses which included anxiety disorder, schizoaffective disorder, tardive dyskinesia, dementia, psychosis and bipolar disorder. The current Minimum Data Set assessment dated 7/16/12 indicated Resident #3 had no falls since admission. The current care plan included a problem area dated 5/11/12 identifying Resident #3, "At risk for falls related to mental status, history of previous falls, poor vision, utilizes assistive devices and psychotropics." Approaches to prevent falls included a tab alert which was added as an approach on 8/12/12. Review of the medical record of Resident #3 revealed on 8/12/12 at 12:00 PM that Resident #3 was found sitting on the floor, in front of her wheelchair. A change of condition report was completed on 8/12/12 which identified an	F 282	**F-282** **Care plans** 1. **1.How Corrective action will be accomplished:** The tab alert was re-applied to the wheelchair and bed of Resident #3 by Nursing staff following identification on the afternoon of October 10, 2012. 2. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing or Designee will complete an audit of all current care plans to identify individual safety interventions and verify these interventions are in place by November 7, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey R Bordo NHA — TITLE: Administrator — (X6) DATE: Oct/31/2012

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 282	Continued From page 1 intervention in response to the fall for a "tab alert at all times". The need for the tab alert for Resident #3 was included on the Resident Care Specialist Assignment Sheet under the heading Accident Prevention. On 10/10/12 at 9:15 AM the Resident Care Specialist Assignment Sheet was identified by the Director of Nursing as the tool in place for nursing assistants to know individualized needs of residents. On 10/10/12 observations were made of Resident #3 which included the following: 11:35 AM Resident #3 was observed alone, in her room, in a high back wheelchair. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. 12:05 PM Resident #3 was observed alone, in her room, in a high back wheelchair. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. 12:35 PM Resident #3 was observed alone, in her room, in a high back wheelchair. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. 12:55 PM Resident #3 was observed alone, in her room, in a high back wheelchair. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. 1:05 PM Resident #3 was observed in her room, in a high back wheelchair. NA #1 was feeding	F 282	**3. The following measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.** The Director of Nursing or Designee will re-educate all Nursing Staff on developing the care plan and the application of care planned safety interventions by November 7, 2012 . **4. The facility will monitor its performance to make sure solutions are**	

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F 282	Continued From page 2 Resident #3 her lunch meal. A tab alert was not in place in the wheelchair. The back of the wheelchair was in an upright position and Resident #3 was observed rocking her upper torso back and forth; in a forward motion. NA #1 was asked if a tab alert was used for Resident #3 and she indicated she did not know. 2:40 PM Resident #3 was observed alone, in her room, in bed. A tab alert was not in place. At the time of the observation NA #1 verified she had been responsible for Resident #3 during her shift which started at 7:00 AM. NA #1 was asked again about a tab alert for Resident #3. NA #1 located the Resident Care Specialist Assignment Sheet, reviewed it, and noted a tab alarm was supposed to be used for Resident #3. NA #1 stated she would have to check with the nurse to know if the tab alert was supposed to be in place in the bed and/or wheelchair. NA #1 noted velcro on the headboard of the bed and a holder on the back of the wheelchair of Resident #3. NA #1 stated the velcro and holder were used for placement of a tab alert. NA #1 looked for the tab alert in the room of Resident #3 and was not able to locate it. 2:55 PM A tab alert was brought to the room of Resident #3 by another staff member and put into place on the bed and clipped to Resident #3. NA #1 could offer no explanation why the tab alert had not been in place for Resident #3. On 10/10/10 at 7:10 PM the Assistant Director of Nursing (ADON) stated care guides were printed off daily for use by nursing assistants. The ADON stated nursing assistants were expected to follow all identified needs for residents. The ADON stated she recently started updating the care guides and typically the care guide was	F 282	**sustained in the following manner.** The Director of Nursing or Designee will randomly observe 10 residents with care planned safety interventions, weekly for 4 weeks then monthly for 2 months, to verify placement and review these 10 care plans to verify accuracy. The results of these observations and reviews will be documented on the audit tool. Opportunities identified as a result of these observations and reviews will be corrected daily by the DON and Designee. These results will be reported during the monthly QAPI meeting for 3 months by the Director of Nursing, the committee will evaluate and make recommendations as indicated. Date of Compliance is November 7, 2012.	

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F 282	Continued From page 3 specific if the tab alert should be used in a chair and/or bed. The ADON stated the tab alert should have been in place at all times for Resident #3 as indicated on the 8/12/12 post fall report.	F 282		