STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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=G	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 protect a resident from slipping in water, by leaving the resident unattended. The resident had a fall, sustaining an Acute Right Patellar Fracture, and required surgical repair. This was evident in 1 of 3 sampled residents (Resident #1) who were reviewed for falls. Findings include: Record review revealed Resident #1 was admitted to the facility on 04/30/14 with cumulative diagnoses of dementia with behavior disturbance, generalized anxiety, and osteoporosis. Review of the Falls Risk Assessment dated 04/30/14 revealed Resident #1 was a high risk for falls. Review of the initial Minimum Data Assessment (MDS) with an Assessment Reference Date(ARD) of 05/07/14 indicated Resident #1 had behaviors that put the resident at significant risk for physical illness or injury, which included wandering. The resident required limited assistance with one person physical assist for	F 323	"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." This plan of correction is the facility's credible allegation of compliance. F323 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. Corrective Action Upon identification of the stated practice, the facility Administrator and Director of Nursing disciplined the C.N.A. responsible for the identified Resident. Identification of Others Nursing and Rehab Team completed review of all Resident Fall Risk Assessments, Fall Care Plans, most recent MDS's, C.N.A. Assignment sheets and conducted visional observation for compliance of fall interventions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa J. Ralph, NHA
TITLE
(X6) DATE: 10/26/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	**1086 MAIN STREET NORTH YANCEYVILLE, NC 27379**

(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	Continued From page 1 bed mobility, transfers, locomotion on and off the unit, and required extensive assistance with toilet use and personal hygiene. Review of the Care Area Assessment (CAA) Summary dated 05/13/14 for Resident # 1 indicated the following care areas were triggered to proceed to the resident ' s care plan: Cognitive loss/dementia, urinary incontinence, behavioral symptoms, falls, and psychotropic drug use. Review of the Care Plan dated 5/13/14 revealed Resident #1 was, " At risk for falls related to : mental status, new admission, psychotropic medication use, ambulatory/incontinent, osteoporosis. " The approaches included: " Observe for potential patterns of falls to identify possible causes, observe for potential medication related causes, encourage resident to ask for assist, ensure resident has proper footwear as indicated and accepted, orient resident to environment, place call light within reach, offer/assist resident to toilet frequently and as accepted, and place frequently used items within reach. " Record review revealed Resident #1 had five falls in June of 2014. A fall occurred on 06/21/14 when the resident was left unattended by staff, and slipped due to water on the floor. Review of the nurses notes dated 06/21/14 at 7:45 AM read, " Resident found lying in a puddle of water with knees pulled up to the chest. Upon getting the resident up, the resident was noted to have a limp to the right leg, when walking. The right knee was noted to be reddened and bruised. "	F 323	All fall incident reports completed during the last 30 days were reviewed by the DON to ensure investigations were completed, care plans updated and interventions implemented. Systemic Changes Fall Risk Residents identified on C.N.A. Resident Care Assignment sheets and new interventions added to sheets during daily IDT meetings, as needed. Residents identified with a fall risk score of 12 or higher, are placed on C.N.A. Resident Care Assignment sheets as Fall Risk. DON, SDC and/or Unit Managers will reeducate all nursing staff on prevention of incidents/accidents on November 6, 2014. DON and Nurse Managers will conduct 5 random audits weekly x 4 weeks and then monthly x 2 months of assessment sheets, care plans and fall interventions of identified residents.	11/12/14 11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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	Continued From page 2 A staff interveiw conducted 10/2/2014 at 10:35 AM with the 3rd shift Charge Nurse (Nurse #1) regarding the fall sustained by Resident #1 on 6/21/14. Nurse #1 revealed " I was on the secured unit around 6:00 AM on 6/21/14. I heard water running, and I went in the bathroom in (Resident #1 ' s) room, and the water was overflowing from the sink. I turned the water off, and I helped (Resident #1) into the dining area. I assigned (NA#4) to stay with (Resident #1) and the roommate in the dining area, while I got towels and blankets to soak up the water. I called housekeeping and no one responded to the call, because there was no housekeeping staff in at that moment. The water had flowed from the bathroom to the resident ' s room near the window. I then went out of the unit, and found a housekeeping aide, who came to the unit approximately 15 -20 minutes later to mop up the water. When I went back to the unit, housekeeping was mopping up water that had flowed into the hallway, and I was told by (NA #2) that (Resident #1) had slipped in the water and had fallen. I assessed the resident, and I noticed both knees were red, and the right knee was more reddened and swollen. The knee cap was sunken in. I called the Doctor and received an order for the X-Ray. " Interview with the Housekeeping Aide and the Housekeeping Supervisor conducted on 10/01/14 at 2:00 PM regarding what was done related to the water overflow in Resident #1 ' s room on 6/21/14. The Housekeeping Aide stated, " I came in at 6:00 AM. Before shift change, I was called to the 600 hall. (Nurse #1) called me because there was a flood in room 607 (Resident #1 ' s room). I started mopping the water up, and I was putting down bath blankets to absorb the	F 323	Monitoring The results of these reviews will be submitted to the QAPI Committee by the Administrator for review by IDT members each month for 3 months. The QAPI Committee will evaluate the effectiveness and amend, as needed. Date of Correction On or before November 12, 2014	11/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ____ B. WING ____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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	Continued From page 3	F 323		

water. About 7:00 AM, I went to get some more blankets to put down. When I left the 600 hall, it was still a little wet, and there was water at the nurse ' s station. "

A direct care staff interview conducted with NA #4 on 10/01/14 at 2:10 PM regarding the the fall for Res. #1. NA #4 stated, " I was on third shift, working between 200 hall and 600 hall. When I got to 600 hall, I was assigned by (Nurse #1) to monitor (Resident #1) and three other residents in the dining area until first shift. When (NA # 2)(my relief) came, she took over the residents, and I clocked out. When asked what it meant to monitor the residents, NA #4 stated, " To monitor means you can ' t leave them by themselves, someone has to be with them, watching them. If they are a fall risk patient, they are subject to fall, and you have to be by their side to assist them walking. If they have a yellow band on, they are considered a fall risk. (Resident #1) was a fall risk at the time. "

A direct care interview was conducted with NA #2 on 10/1/14 at 3:00 PM, regarding the circumstances surrounding Resident #1 ' s fall of 06/21/14. NA #2 indicated, " When I came in about 6:56 AM, NA #4 was with (Resident #1) in the hallway in front of the resident ' s room. Water was still on the floor. (NA #4) left the resident with me, because (NA #4) had to clock out. I told the resident to go in the opposite direction down the hallway, and I started my rounds. I left the resident alone, while I went to do my rounds. I was there by myself for about 5 minutes, then everybody else(referring to Nursing and Nursing Assistant staff) started coming in. I had started rounds with my first resident, when (NA # 3) came and got me out of the room and told me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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	Continued From page 4 (Resident #1) was on the floor. Me (NA#2) and (NA #3) ambulated (Resident #1) and took (Resident #1) into the dining room. We noticed (Resident #1) was not ambulating well, and when I pulled the gown back to check, I noticed the whole right knee was pushed in and flat, the knee cap was higher than where it was supposed to be. (NA#3) got (Nurse #1) off the main hall. (Nurse #1) assessed (Resident #1), and told me to sit with (Resident #1), until (Nurse #1) could call and get an X-Ray done for the knee. The doctor looked at the X-Ray, and sent (Resident #1) to the hospital. " When asked about the facility protocol for a resident who is at risk for falls on the secured unit, NA #2 stated, " We are supposed to keep them out of harms way, and monitor the fall risk residents by walking the resident with use of a gait belt to make sure they don ' t fall, and also observing the residents during activities and /or sit with the resident. I know we are not supposed to leave them alone. " Review of the hospital record for the admission of 06/21/14 revealed Resident #1 sustained an acute fracture of the right knee patellar and had an open reduction internal fixation surgery on 6/22/14 to repair the fracture. A direct care staff interview was conducted on 09/30/2014 at 4:25 PM with Nurse # 2 regarding the current monitoring needs of Resident #1. Nurse #2 indicated, " (Resident #1) is on close supervision because of being a falls risk, and a nursing assistant has to stay with (Resident #1) when in the dining room. " A direct care staff interview conducted on 09/30/14 at 4:30 PM with Nursing Assistant (NA #5) indicated Resident #1, " Can now walk and is	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	**1086 MAIN STREET NORTH YANCEYVILLE, NC 27379**

(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	Continued From page 5 total care. " When asked how NA #5 prevented the resident from having further falls, NA #5 revealed, " We walk with (Resident #1), there is an alarm on the bed, and a fall mat beside the bed when the resident is in bed. " Observation of Resident #1 ' s room on 09/30/14 at 4:45 PM verified the use of an alarm on the bed, with the bed in low position. A fall mat was observed stored behind the bed. Resident #1 was observed in the dining room seated at the dining table. A staff member was observed seated next to the resident. Interview with the Administrator and the DON conducted on 10/1/14 at 3:15 PM revealed the facility recognized a problem with falls the first of June, 2014. The Administrator indicated, " We had a lot falls in May, when I first got here. In June we started a different method of investigating falls, with actually looking at the root cause of the falls. " The DON stated, " I don ' t know what date we actually started monitoring. " The Administrator stated, " There is a Performance Improvement Plan for residents at risk for falls. The Quality Assurance Program is done during the morning Interdisciplinary meeting when all falls are reviewed, then we have several meetings throughout month for reviewing at risk residents (At Risk Review Meeting) when each resident is discussed , then we discuss the trends bimonthly with the Medical Director and the entire Interdisciplinary team. For instance, with falls, the falls started to decline in June, and we have continued to trend down. This month, we did not flag for falls. " Interview with the Administrator conducted 10/1/14 at 4:40 PM indicated, " There is no	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ______ B. WING ______	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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	Continued From page 6 documentation of monitoring for residents at risk for falls on the secured unit. We will need to change that. " Review of the facility in-service dated 6/25/14 entitled, " In-Service with 600 Hall Staff " presented by the DON included: Cleaning up spills as soon as noted, fall interventions, alarms on and answering alarms and call lights, rounds, reducing falls, and non-skid socks available. Interview conducted with the Administrator on 10/2/14 at 4:40 PM revealed the expectations of the Administrator regarding falls in facility included : " To have immediate corrective action after assessment for need, look at the root cause of the fall to make sure no one else is harmed, look at who else/other residents would be affected by the situation, look at our present systems and evaluate for effectiveness, and implement additional interventions as needed, monitor the systemic change to see if its working, and make adjustments as needed. " Interview with the Administrator on 10/1/14 at 2:30 PM revealed, " NA #2 (the assigned NA) was not following protocol to monitor the resident prior to the fall. "	F 323		