STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING ______ B. WING ______	C 01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #SQK511.	F 000		
F 170 SS=B	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail on Saturdays for 2 of 3 resident reviewed for mail delivery. (Residents #21 and #49). The findings included: 1. Resident #21 was admitted to the facility on 01/12/06. Record review of a most recent Minimum Data Set (MDS) dated 10/14/14 revealed she was coded as cognitively intact. On 01/07/15 at 11:43 AM an interview was conducted with Resident #21. She revealed the United States Postal Service (USPS) had delivered mail to the facility on Saturdays and residents had received mail on Saturdays until approximately 1 month ago. Resident #21 revealed she had received her church bulletin on Saturdays and since the mail had not been passed out on Saturdays she does not receive the bulletin until Monday. She said she wanted to receive the bulletin on Saturday because she would be able to keep up with her church programs. Resident #21 reported she had asked	F 170	F 170 1. Corrective action has been accomplished for the alleged deficient practice in regards to mail delivery on Saturdays by assigning a staff member to obtain and deliver mail during their shift on Saturdays. 2. Facility residents have the potential to be affected by the same alleged deficient practice. Therefore, the Administrator has assigned mail delivery as a task for the Restorative Aide while on duty on Saturdays. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Social Worker will conduct in-service/re-education for the Activities Director and Restorative Aide regarding the provision of mail delivery on each day the mail is delivered as part of the residents□ rights while residing at the facility. The Administrator or Social Worker will randomly interview three residents on a weekly basis for four	2/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/27/2015

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 170	Continued From page 1 staff if residents could receive their mail on Saturdays and staff replied, ' they would see.' On 01/08/15 at 4:45 PM an interview was conducted with the Activity Director. She revealed the USPS delivered mail to the facility on Saturdays and a restorative aide who worked on Saturdays passed the mail out on the weekend until she quit approximately 1 month ago. The Activity Director stated she does not work on Saturdays and she asked the other restorative aide who works on Saturdays if she would pass the mail out on Saturday. The Activity Director said the restorative aide replied she did not have time to pass the mail out on Saturdays and it was not in her job description. The Activity Director stated residents should receive mail on Saturdays. On 01/08/15 at 5:57 PM an interview was conducted with the Administrator. He said the Activity Director had given mail to a resident who delivers the mail to residents during the week. He stated that a staff member gets the mail from the USPS box for the facility and had delivered it on Saturdays. The Administrator revealed it was the first time he had heard the restorative aide had not delivered the mail on Saturdays. The Administrator stated the expectation had been the restorative aide should deilver the mail on Saturdays and it was part of her job. 2. Resident #49 was admitted to the facility on 05/31/09. Review of her most recent MDS dated 12/08/14 revealed she was coded as cognitively intact. On 01/08/15 5:36 PM an interview was conducted with Resident #49. She revealed a restorative aide, who was no longer working at the facility, delivered the mail on Saturdays and when she left	F 170	weeks to identify concerns related to mail delivery, and will review Resident Council Meeting minutes monthly for four months to identify concerns related to mail delivery to ensure continued compliance. 4. The Administrator or Social Worker will review data obtained during interviews and Resident Council Meetings, analyze the data and report patterns/trends to the QAPI committee every other month for four months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on identified outcomes to ensure continued compliance.	

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F 170	Continued From page 2 another restorative aide was to deliver the mail on Saturday. Resident #49 stated it had been approximately 1 month ago when the aide left that mail had not been delivered on Saturday. Resident #49 said she used to receive mail from her sister on Saturdays and now she does not get the mail from her sister until Monday. On 01/08/15 at 4:45 PM an interview was conducted with the Activity Director. She revealed the USPS delivered mail to the facility on Saturdays and a restorative aide who worked on Saturdays passed the mail out on the weekend until she quit approximately 1 month ago. The Activity Director stated she did not work on Saturdays and she asked the other restorative aide who worked on Saturdays if she would pass the mail out on Saturday. The Activity Director said the restorative aide replied she did not have time to pass the mail out on Saturdays and it was not in her job description. The Activity Director stated residents should receive mail on Saturdays. On 01/08/15 at 5:57 PM an interview was conducted with the Administrator. He said the Activity Director had given mail to a resident who delivered the mail to residents during the week. He stated that a staff member gets the mail from the USPS box for the facility and had delivered it on Saturdays. The Administrator revealed it was the first time he had heard the restorative aide had not delivered the mail on Saturdays. The Administrator stated the expectation had been the restorative aide should deliver the mail on Saturdays and it was part of her job.	F 170		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		2/5/15

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F 242	Continued From page 3 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to assess and provide food preferences for a resident at risk for weight loss for 1 of 2 residents reviewed for choices. (Resident #83). The findings included: Resident #83 was admitted to the facility 12/21/14 with diagnoses which included a fractured hip, esophageal reflux, and osteoporosis. A review of Resident #83's medical record revealed the resident's weights were recorded as follows: 12/21/14 weight was 114 pounds, 12/23/14 weight was 114 pounds, 12/30/14 weight was 111, and 01/05/15 weight was 111. Further medical record review revealed there were no dietary notes or assessments on this resident's chart. An admission Minimum Data Set (MDS) dated 12/28/14 indicated the resident's cognition was moderately impaired, speech was clear and could be understood and the resident understood others. The MDS specified the resident required extensive staff assistance with bed mobility, dressing, toilet use, and personal hygiene. The	F 242	F 242 1. Corrective action has been accomplished for the alleged deficient practice for Resident # 83 by assessing the resident□s likes and dislikes related to food preferences. 2. Facility residents have the potential to be affected by the same alleged deficient practice. Therefore, the Dietary Manager has conducted an audit of current residents□ medical records and tray cards to ensure that likes/dislikes are recorded in the medical record and in the tray card system. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The MDS Coordinator/Health Information Manager will conduct in-service/re-education for Interdisciplinary Team, including the Dietary Manager, regarding the resident□s right to make choices related to areas of life in the facility that are important to them; specifically, each resident should be interviewed for their food preferences, likes, and dislikes so that the information can be entered into the facility□s meal tray system. The Health Information Manager or Dietary	

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F 242	Continued From page 4 MDS further specified the resident required supervision with eating. The MDS contained documentation of 111 pounds for weight and 64 inches (5 feet 4 inches) for height. An observation on 01/07/15 at 8:14 AM revealed Resident #83's breakfast tray contained scrambled eggs, bacon, toast, milk, orange juice and coffee. The resident was observed to consume all her breakfast except for the orange juice. During an interview on 07/07/15 at 8:23 AM, Resident #83 stated breakfast was the best meal of the day. The resident added she got orange juice today and does so frequently. She explained she cannot drink orange juice because it soured her stomach. The resident stated she liked apple juice. The resident added she drank apple juice at home and would like it on her breakfast tray. Resident #83 was unable to recall if the facility had asked what foods she liked or disliked. Resident #83's breakfast tray card was observed at this time. There was no listing for food preferences on the tray card. An observation was conducted on 01/07/15 at 12:22 PM of Resident #83 eating her lunch. Chicken in a tomato sauce, spaghetti noodles, green salad, pudding, and iced tea were observed on her lunch tray. At this time, Resident #83 stated she could not eat a green salad. It bothered her stomach. The resident also stated she did not care for spaghetti noodles. She added she would love to have milk for lunch. Resident #83 explained she does not ask staff to bring her milk. She added they were busy and she didn't want to bother them. Resident #83 stated she kept apple juice and yogurt at home	F 242	Manager will review new admission charts to identify that likes/dislikes have been documented and are transcribed to the meal tray system. The MDS Coordinator/Health Information Manager or Social Services Director will conduct random interviews with at least three interviewable residents weekly for four weeks, then at least three interviewable residents per month for three months to ensure continued compliance with providing foods that are compatible with the residents□ likes and dislikes. The Food Preference Interview will be added as part of the admission packet to insure prompt initial assessment of food preferences. 4. The Administrator or Social Services Director will review data obtained during the audits and interviews, analyze the data and report patterns/trends to the QAPI committee every other monthly for four months. The QAPI committee will evaluate the effectiveness of the above plan, and will add additional interventions based on outcomes identified to ensure continued compliance.	

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F 242	Continued From page 5 for snacking and would like that to be available for her in the facility. An observation of the lunch tray card revealed no food preferences were listed. An interview with the Director of Food Service (DFS) was conducted on 01/07/15 at 4:13 PM. The DFS explained it had been their practice to obtain food preferences from newly admitted residents within 48 hours of their admission. She added initial dietary assessments should be completed within 7 days of admission. She stated in October, the facility went with a new dietary management company. Since that time, kitchen staff hours had been cut. The DFS stated the Assistant Director of Food Service (ADFS) obtained the food preferences, but since the cut in kitchen staff hours, the ADFS had functioned as a cook. The DFS stated she had also worked in the kitchen because of the decrease in kitchen staff hours. She explained due to this, she was having challenges getting dietary assessments completed. An interview was conducted with the Registered Dietician (RD) on 01/08/15 at 11:32 AM. The RD was familiar with Resident #83 related to a previous recent admission. She stated the resident was at risk for weight loss related to a Body Mass Index (BMI) of 19 on the previous admission. The RD explained this BMI was within normal limits for this resident. A BMI of 17 would register as underweight. The RD stated it was important to provide foods for Resident #83 that she would eat to maintain her present BMI.	F 242		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		2/5/15

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F 323	Continued From page 6 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 medical record review, observations and staff interview the facility failed to follow care plan interventions to prevent falls for 1 of 3 sampled residents reviewed for falls. (Resident #110) The findings included: Resident #110 was originally admitted to the facility 04/21/11 with diagnoses which included dementia and a recent hip fracture. The current Minimum Data Set (MDS) assessment dated 10/14/14 assessed Resident #110 with severe cognitive impairment. The last fall risk assessment completed 10/14/14 (completed after Resident #110 returned to the facility after sustaining a right hip fracture) noted a score of 20 with 10 or greater noted as a high risk for falls. The current care plan dated 10/17/14 for Resident #110 included the following problem areas: -Requires staff assistance and intervention for completion of activity of daily living (ADL) needs with extensive assistance to total care utilizing 1-2 staff due to recent hip fracture and non ambulatory. Approaches to address this problem area included individual/caregiver education as	F 323	F 323 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 110 by providing appropriate oversight during toileting according to the plan of care. The information on the Resident Care Specialist Assignment Sheet has been updated to reflect current interventions for this resident. 2. Residents who have been identified as being at risk for falls have the potential to be affected by the same alleged deficient practice. Therefore, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) have completed an audit of current residents� care plans and Resident Care Specialist Assignment Sheets to determine that interventions related to fall reduction and/or prevention are current and accurate. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Director of Nursing or Assistant Director of Nursing will conduct in-service/re-education for licensed nurses and Resident Care Specialists regarding the requirement that each	

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needed.
-At risk for falls related to mental status, recent fall, history of falls, poor vision, balance problem/standing, balance problem/walking, utilizes assistive device, decreased muscle coordination, change in gait pattern, arthritis, fracture with repair of hip on 09/26/14, narcotic use and psychotropic use. Approaches to address this problem area included to provide assistance with transfers. The care plan for falls identified all falls Resident #110 had in 2014. These falls included:
03/14/14-Resident #110 was standing at her closet, reaching up to get clothes when she lost her balance and fell. 2 centimeter (cm) X 2 cm hematoma left side of head surrounding a small abrasion.
05/20/14- Resident #110 got up to go to the bathroom without assistance using a walker to ambulate. Resident #110 stated she slipped and fell when trying to sit down to use the bathroom.
07/19/14-Resident #110 was walking to the trash can and her clothes got hung on the bed rail and resident fell on her buttocks, on the floor.
09/25/14-Resident #110 was standing at her dresser attempting to put her jacket in the drawer. Resident #110 started stumbling backwards and fell hitting her head on the roommate's bed and landed on her side on the floor. Resident #110 sustained a right hip fracture and was hospitalized for repair.
12/07/14-Resident #110 was assisted to toilet by a nursing assistant. The nursing assistant stepped out of the bathroom to get a brief for the resident. Resident #110 attempted to transfer from toilet to her wheelchair and fell. Resident #110 sustained a laceration to her forehead which measured 7 cm X 3 cm, a hematoma to the right side of her head, above the ear which measured

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resident receive adequate supervision and assistive devices to prevent accidents; specifically, that interventions put in place to reduce the potential for accidents are noted on the care plan and Resident Care Specialist Assignment Sheet and should be followed for resident safety. The DON or ADON will review incidents/accidents on a daily basis, Monday through Friday, during the Interdisciplinary Team meeting and the team will make changes to care plans based on resident need. The DON or ADON will update the Resident Care Specialist Assignment Sheets with pertinent care information related to fall reduction/prevention as new interventions are identified. The DON, ADON, or Unit Coordinator will conduct rounds at least 3 times per week for four weeks and then at least weekly for three months, using the Resident Care Specialist Assignment Sheets, to identify that necessary interventions are being employed to ensure continued compliance. To ensure continued compliance Individual Falls Review will be added as a permanent agenda item for the IDT morning meeting. Each fall will be reviewed by the team daily (M_F) and specific, changes to and updates of individual programs/protocols will be added at that time.
4. The Director of Nursing or Assistant Director of Nursing will review data obtained during Interdisciplinary Team meetings and care rounds, analyze the data and report patterns/trends to the QAPI committee every other month for four months. The QAPI committee will evaluate the effectiveness of the above

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F 323	Continued From page 8 7 cm X 6 cm and a mild occipital hematoma. Approaches put in place as a result of this fall included hospitalization for evaluation and treatment and to instruct the nursing assistant to not leave Resident #110 unattended in the bathroom. An incident report from the 12/07/14 fall noted Resident #110 attempted to transfer herself from the toilet to wheelchair without assistance and that Resident #110 fell and hit her head on the wheelchair, causing a laceration to her forehead. The incident report indicated when falling on the floor, Resident #110 fell on her right side, causing a hematoma to right side of head. The incident report noted interventions put in place to prevent further falls included care plan revision and staff education. On 01/07/15 at 10:30 AM management Nurse #1 provided a copy of the nursing assistant care guide which included individual instructions related to Resident #110. Nurse #1 stated the care guide was updated daily as needed by nurses and utilized by nursing assistants to know the care needs of residents. The care guide for Resident #110 was provided at the time of the interview and did not indicate she was at risk for falls. The care guide did not include anything related to falls approaches under the heading "special needs/instructions" to inform nursing assistants not to leave Resident #110 unattended in the bathroom. On 01/08/14 at 11:00 AM the call light was observed engaged in the room of Resident #110. Upon entering the room Resident #110 stated she needed to use the bathroom. NA #1 responded to the call light and Resident #110 asked to be	F 323	plan, and will add additional interventions based on identified outcomes to ensure continued compliance.	

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taken to the bathroom. NA #1 closed the door of the room and assisted Resident #110 into the bathroom which adjoined her room. Upon entering the room, NA #1 was observed in the bathroom with Resident #110. Resident #110 was seated on the commode. NA #1 stated to Resident #110 that she was going to get a brief and she would be right back. NA #1 left the room for approximately 30 seconds leaving Resident #110 unattended in the bathroom. Upon return, NA #1 went back in to the bathroom with Resident #110, stepped out momentarily to get the wheelchair (which was at the bedside of Resident #110) and assisted the resident into the wheelchair. Immediately after this observation NA #1 was interviewed about Resident #110. NA #1 stated she worked on all halls within the facility and had worked on the hall Resident #110 resided "this week". NA #1 stated the other nursing assistant assigned to the hall was at lunch so she was by herself at the time she assisted Resident #110 to the bathroom. NA #1 stated she refers to the care guide and any instructions relayed to her by other nursing assistants to know individual needs of residents. NA #1 stated she was aware Resident #110 needed assistance with transfers but did not think she was at risk for falls because she did not wear a tab alarm. NA #1 stated she was not aware of any special needs involving Resident #110.

On 01/08/15 at 2:10 PM the Director of Nursing (DON) stated any nurse can update the nursing assistant care guides when a change in care needs is identified. The DON stated the Assistant Director of Nursing (ADON) typically addressed falls and any change in care needs would be updated by the ADON on the care guide. The DON stated Resident #110 should never be left

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F 323	Continued From page 10 unattended when seated on the commode. The DON stated she thought all the nursing assistants were aware of this and wasn't aware it had not been placed on the nursing assistant care guide. The DON stated the nursing assistant that left Resident #110 alone in the bathroom on 12/07/14 was inserviced about not leaving Resident #110 unattended in the bathroom. The DON stated other nursing assistants would have known this via the care guide. On 01/08/15 at 2:45 PM the ADON stated she usually placed information like "do not leave unattended in the bathroom" on the care guide but must have inadvertently left it off for Resident #110 when the new intervention was put in place after the fall on 12/07/14.	F 323		