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 05/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD 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=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 reviews, and staff interviews the facility failed to implement intervention of mechanical lift transfer which resulted in 1 of 3 sampled residents (Resident#1), sustaining a laceration which required sutures. Findings included: A record review of quarterly Minimum Data Set (MDS) dated 02/20/15 revealed Resident #1 was admitted to the facility on 02/20/08 and was cognitively impaired. Resident #1 was diagnosed with hemiplegia and non-Alzheimer's dementia. Resident #1 required extensive assistance with bed mobility, transfers, toilet use and personal hygiene. A record review of Resident #1's care plan most recently updated on 02/04/15, revealed an identified problem with transfers. Resident #1 required use of mechanical sit to stand lift for transfers. An intervention for Resident #1 included providing a mechanical lift for transfers. Nurse's situation, background, assessment, and	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 provision of federal and state law." F323 1. Corrective action was accomplished for the alleged deficient practice in regard to Resident #1 by providing appropriate medical treatment to laceration of toe. Care Plan and Resident Care Assignment sheet was checked for accuracy. 2. All residents requiring assistance with transfers have the potential to be affected by the alleged deficient practice. Director of Nursing (DON), Unit Manager (UM) or Staff Development Coordinator (SDC)	5/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 05/29/2015

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 323	Continued From page 1 recommendation (SBAR) note dated 03/09/15, indicated Resident #1 received laceration to right foot 3rd toe, full thickness laceration required stitches, transferred to hospital. Resident #1 was on blood thinner. A record review of physician's order dated 03/09/15 revealed staff were ordered to send resident to the emergency room for toe laceration. A record review of emergency room discharge note dated 03/09/15 revealed Resident #1 had a diagnosis of toe laceration which required sutures. An interview with unit manager was conducted on 05/06/15 at 2:50 PM. Unit manager stated Resident #1's care plan indicated Resident #1 required mechanical sit to stand lift for transfers and could not be transferred using 2 person physical assist without using mechanical lift as per care plan. Unit manager stated Nurse Aide #1 and Nurse Aide #2 no longer worked at the facility and were not available for interview. An incident and accident form was completed that indicated Nurse Aide #1 and Nurse Aide # 2 were involved with the accident that occurred with Resident #1. An interview with the Director of Nursing (DON) was conducted on 05/06/15 at 4:08 PM. DON stated Nurse Aide #1 and Nurse Aide #2 performed a 2 person physical transfer of Resident #1 without using mechanical sit to stand lift as per Resident #1's care plan. DON stated Resident #1 was noted to have injury to right foot 3rd toe. DON revealed toe injury was noticed when Resident #1 was sitting in the shower chair post transfer without using mechanical sit to	F 323	have reviewed all Care Plans and Resident Care Assignment sheets to determine that interventions are current and accurate. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: in-service/re-education training for licensed nurses and Resident Care Specialists regarding the requirement that each 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 sheets and should be followed for resident safety. Education also included Lift and Transfer policy and the incident/accident policy. DON, UM or SDC audited all Resident Care Assignment sheets for accuracy. DON, UM or SDC will conduct rounds at least 3 times per week for four weeks and then at least weekly for three months, using the Resident Care assignment sheets and audit tool, to identify that necessary interventions are being employed to ensure continued compliance. 4. DON, UM or SDC will review data obtained during Interdisciplinary Team meetings, analyze the data and report patterns/trends to the QAPI committee every 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	

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F 323	Continued From page 2 stand lift. DON revealed Resident #1 went to the emergency room on 03/09/15 and received stitches and returned to the facility on 03/09/15. DON stated statements obtained from Nurse Aide #1 and Nurse Aide #2 revealed they did not use the mechanical lift to transfer Resident #1. Nurse Aide #1 and Nurse Aide #2 statements indicated they used 2 person physical assist to transfer Resident #1. DON stated Nurse Aide #1 and Nurse Aide #2 were counseled and educated on the use of mechanical lifts and to follow resident care plan. Nurse Aide #1 and Nurse Aide #2 were informed by DON that any further infractions would result in discharge. A telephone interview was conducted with Nurse #1 on 05/07/15 at 10:20 AM. Nurse #1 stated she remembered Resident #1 was sitting in a shower chair at doorway of her room with feet dangling and blood was on the floor under her feet. Nurse #1 stated she thought Resident #1 had a loose toe nail and wrapped foot in plastic bag so Resident #1 could finish her shower. Nurse #1 stated after dinner when Resident #1 was lying in bed, she reassessed Resident #1's foot and discovered Resident #1 had a full thickness laceration of foot which began to bleed and required stitches. Nurse #1 stated Resident #1 was transferred via ambulance to the hospital. Nurse #1 stated at the beginning of the shift on 3/09/15, she provided Nurse Aide #1 and Nurse Aide #2 with a nurse aide care guide (plan of care) for Resident #1. Nurse #1 stated it was the responsibility of Nurse Aide #1 and Nurse Aide #2 to read and follow the plan of care for Resident #1. A record review of Nurse Aide #1's nurse aide attention to daily living (ADL) detailed report sheet	F 323	compliance.	

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F 323	Continued From page 3 documentation for 03/09/15 revealed Nurse Aide #1 documented Resident #1 required extensive assistance for transfers and was transferred using one person physical assist. An interview was conducted with the DON on 05/07/15 at 12:15 PM. DON stated Nurse Aide #1 and Nurse Aide #2 did not attend safe transfer in-service provided on 03/06/15. DON stated her expectations were for Nurse Aide #1 and Nurse Aide #2 to follow the interventions on the care plan guide provided to them at the beginning of the shift that indicated Resident #1 required mechanical sit to stand lift for transfers. DON stated her expectations were that Nurse Aide #1 and Nurse Aide #2 would not have transferred Resident #1 using 2 person physical assist. An interview was conducted with the Administrator on 05/07/15 at 1:05 PM. The Administrator stated her expectations were that staff would follow care guides to know what care was needed to be provided for residents. Administrator stated her expectations were that nurses on the unit would monitor that nurse aides implemented interventions on the nurse aide care guide for the resident.	F 323		