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 11/18/2016

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #R0QT11.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to provide an activity program designed to meet the physical, mental, and psychosocial well-being for 2 of 4 residents reviewed for activities (Resident #42 and #122). The findings included: 1. Resident #42 was admitted to the facility on 11/25/14. The annual MDS dated 08/03/16 and the following quarterly MDS dated 10/27/16 both indicated Resident #42 had no cognitive impairment. Resident #42 required extensive assistance with bed mobility and transfers. Review of the CAA summary indicated activities did not trigger as a potential concern for Resident #42 and no specific activity care plan was created. The MDS indicated Resident #42 stated the following activities were very important for her to participate in: having books, newspapers, and magazines to read. Resident #42 also stated it was somewhat important for her to do things with groups of people, to be outside in good weather, to be around animals/pets and to be a part of	F 248	"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 by the provision of Federal and State law." 1. Resident of #42 and resident #122 had their activity assessment updated and specific activities care plan in place to include evening activities and outside activities as weather permits. Resident #42 was provided with a large print activity calendar. Corrective action for the alleged deficient practice for resident #42 and resident #122 was accomplished by completing the activity assessment and initiating a specific activities care plan. These measures were completed on 11/22/16.	12/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/16/2016

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 11/18/2016

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F 248	Continued From page 1 religious services. During an interview on 11/15/16 at 8:32 AM, Resident #42 stated "they don't have anything at night and I'd like to see something (activities) at night as long as it wasn't too late like after 8:00 PM or so." Resident #42 also stated "they don't ever have anything (activities) after dinner." During a 2nd interview on 11/17/2016 at 10:51 AM, Resident #42 stated she had not been invited to any activity and she had not attended any activity this week. Resident #42 also stated she was not able to see or hear and staff "just don't invite me" to activities. Resident #42 was informed about the activities during the week and she stated she would have liked to have attended either of the music activities, but she had not been invited. Resident #42 further stated she had an activity calendar in her room but the print was too small for her to read. A review of the activity calendars utilized by the facility from June 2016 to November 2016 revealed the following scheduled activities in the evening (after 5:00 PM): June 8 - Church 7:00 PM; June 20 - Pisgah Mtn. Travelers (musical group) 6:30 PM July 13 - Church 7:00 PM; July 18 - Pisgah Mtn. Travelers 6:30 PM August 10 - Church 7:00 PM; August 15 - Pisgah Mtn. Travelers 6:30PM September 14 - Church 7:00 PM; September 19 - Pisgah Mtn. Travelers 6:30 PM October 17 - Pisgah Mtn. Travelers 6:30 PM November 21 - Pisgah Mtn. Travelers 6:30 PM Review of the documented attendance from June 2016 through November 2016 revealed Resident #42 had not been invited nor attended the 10 evening activities offered during this 6 month	F 248	2. All resident have the potential to be affected by the alleged deficient practice, therefore Resident Care Management Director and/or designated department manager interviewed current residents on their activity preferences and completed an audit of current resident activity assessments to update activity preferences and times to ensure specific activity calendar in place. 3. Measure put in place to ensure the alleged deficient practice does not re-occur include: The Administrator re-educated the Activity Director of the importance of initial activity assessments to identify types of activities and activity times important to the residents. Education also included on-going assessments and care planning. The Administrator or Department manager will randomly audit 10 residents weekly x12 weeks to ensure activities are being offered and provided as scheduled. The Administrator or Department Manager will randomly observe 10 residents/week x12 weeks to verify appropriate participation in care planned activities. 4. Results of audits will be reviewed by the Administrator and reported to the QAPI committee monthly x3 months, then as recommended by the QAPI committee.	

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 11/18/2016

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F 248	Continued From page 2	F 248		

period.
During observations throughout the week Resident #42 was not seen in any scheduled activities. No evening activities were listed on the calendar during the five days of survey. The latest scheduled activity for the week was at 3:30 PM.
During an observation of the activity (Music 2:00 PM) listed on the activity calendar for 2:00 PM on 11/15/16, an observation made at 2:15 PM and at 2:31]xzPM revealed Resident #42 was not present. The AD was observed as being present during the activity, with 15 - 20 residents present throughout the activity.

During an observation of the activity (10:00 AM Scrabble) for 10:00 AM on 11/16/16, an observation made at 10:12 AM and 10:30 AM revealed Resident #42 was not present. The AD was observed during this time to be sitting with 2 other residents playing Scrabble.

During an observation of the activity (3:00 PM Bingo) for 3:00 PM on 11/16/16, an observation made at 3:18 PM and at 3:42 PM revealed Resident #42 was not present. The AD was observed during this time to be conducting the activity with 10 residents present.

During an observation of the activity (2:30 Movie and Popcorn) for 2:30 PM on 11/17/16, an observation made at 3:00 PM revealed Resident #42 was not present. The AD was observed during this time to be conducting the activity with 14 residents present.

Record review of Resident Council Minutes (RCM) for July 2016 indicated concerns from residents stated the activities on the calendar did

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 11/18/2016

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F 248	Continued From page 3	F 248		

not always occur as scheduled. This concern was resolved and there were no further concerns noted in RCM for August 2016 through November 2016 regarding activities.

During an interview on 11/18/16 at 9:15 AM the Activity Director (AD) stated she had an Activity Assistant full time from January to March 2016. The Activity Assistant (AA) left in March and that position had not been filled. The AD stated they had no consistent volunteers that came in to help her with activities and she was doing what she could for 78-80 residents. The AD stated her goal was for the resident's to be stimulated and for their lives to be as happy as she could possibly make them. The AD stated if she had a full time assistant they would be able to provide more evening and weekend activities, and much more could be done with the residents. The AD also stated she was responsible for getting all the residents to and from activities. The AD further stated the Nurse Aides (NA) would help get residents to the activities, but only if she asked for assistance from them. The AD acknowledged she had an AA that was supposed to be available for 2 hours each day but this rarely occurred since the AA worked in another department at the facility. The AD also acknowledged she had just recently expressed during an Interdisciplinary Team Meeting (IDT) it was very hard for her to get everything done that she needed to since it was only her doing activities.
During an interview on 11/18/16 at 11:48 AM with the Administrator (ADM) stated they had been posting for a full time activity assistant position and had not been able to find an employee for this position since it was vacated in March 2016. The ADM also stated they were reaching into the community to find volunteers, including the local

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 11/18/2016

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F 248	Continued From page 4	F 248		

churches, high schools and through the community resource program. The ADM stated her expectation was for the residents to have activities that were resident centered according to their preferences and the facility would have a robust activity program that would meet the needs and the wants of the residents.

2. Resident #122 was admitted to the facility on 08/26/16 initially, discharged on 08/28/16 and readmitted on 09/01/16. The admission MDS dated 09/09/16 indicated Resident #122 had moderate cognitive impairment. Resident #122 required supervision with bed mobility and transfers. Review of the CAA summary indicated activities did not trigger as a potential concern for Resident #122 and no specific activity care plan was created.

The MDS indicated Resident #122 stated the following activities were very important for him to participate in: keeping up with the news and being outside when the weather was good. Resident #122 also stated it was somewhat important for him to do things with groups of people, to be around animals/pets, listening to music, having books, newspapers and magazines to read, and to be a part of religious services.
During an interview on 11/15/16 at 9:48 AM, Resident #122 stated "there is a lot of down time in the evenings." Resident #122 also stated he watched a lot of television in his room because there was nothing else to do.
A review of the activity calendars utilized by the facility from June 2016 to November 2016 revealed the following scheduled activities in the evening (after 5:00 PM):

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 11/18/2016

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F 248	Continued From page 5	F 248		

June 8 - Church 7:00 PM; June 20 - Pisgah Mtn. Travelers (musical group) 6:30 PM
July 13 - Church 7:00 PM; July 18 - Pisgah Mtn. Travelers 6:30 PM
August 10 - Church 7:00 PM; August 15 - Pisgah Mtn. Travelers 6:30PM
September 14 - Church 7:00 PM; September 19 - Pisgah Mtn. Travelers 6:30 PM
October 17 - Pisgah Mtn. Travelers 6:30 PM
November 21 - Pisgah Mtn. Travelers 6:30 PM

During observations throughout the week Resident #122 was not seen in any scheduled activities. No evening activities were listed on the calendar during this week. The latest scheduled activity for the week was at 3:30 PM.

During an observation of the activity (Music 2:00 PM) listed on the activity calendar for 2:00 PM on 11/15/16, an observation made at 2:15 PM and at 2:31PM revealed Resident #122 was not present. The AD was observed as being present during the activity, with 15 - 20 residents present throughout the activity.

During an observation of the activity (10:00 AM Scrabble) for 10:00 AM on 11/16/16, an observation made at 10:12 AM and 10:30 AM revealed Resident #122 was not present. The AD was observed during this time to be sitting with 2 other residents playing Scrabble.

During an observation of the activity (3:00 PM Bingo) for 3:00 PM on 11/16/16, an observation made at 3:18 PM and at 3:42 PM revealed Resident #122 was not present. The AD was observed during this time to be conducting the activity with 10 residents present.

During an interview conducted on 11/17/16 at

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 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 248	Continued From page 6	F 248		

2:07 PM Nurse Aide #4 (NA #4) stated he had never seen Resident #122 attend any activities.

During an observation of the activity (2:30 Movie and Popcorn) for 2:30 PM on 11/17/16, an observation made at 3:00 PM revealed Resident #122 was not present. The AD was observed during this time to be conducting the activity with 14 residents present.

Record review of Resident Council Minutes (RCM) for July 2016 indicated concerns from residents stated the activities on the calendar did not always occur as scheduled. This concern was resolved and there were no further concerns noted in RCM for August 2016 through November 2016 regarding activities.

During an interview on 11/18/16 at 9:15 AM the Activity Director (AD) stated she had an Activity Assistant full time from January to March 2016. The Activity Assistant (AA) left in March and that position had not been filled. The AD stated they had no consistent volunteers that came in to help her with activities and she was doing what she could for 78-80 residents. The AD stated her goal was for the resident's to be stimulated and for their lives to be as happy as she could possibly make them. The AD stated if she had a full time assistant they would be able to provide more evening and weekend activities, and much more could be done with the residents. The AD also stated she was responsible for getting all the residents to and from activities. The AD further stated the Nurse Aides (NA) would help get residents to the activities, but only if she asked for assistance from them. The AD acknowledged she had an AA that was supposed to be available for 2 hours each day but this rarely occurred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 7 since the AA worked in another department at the facility. The AD also acknowledged she had just recently expressed during an Interdisciplinary Team Meeting (IDT) it was very hard for her to get everything done that she needed to since it was only her doing activities. During an interview on 11/18/16 at 11:48 AM with the Administrator (ADM) stated they had been posting for a full time activity assistant position and had not been able to find an employee for this position since it was vacated in March 2016. The ADM also stated they were reaching into the community to find volunteers, including the local churches, high schools and through the community resource program. The ADM stated her expectation was for the residents to have activities that were resident centered according to their preferences and the facility would have a robust activity program that would meet the needs and the wants of the residents.	F 248		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to provide nail care to 1 of 1 sampled dependent residents with severely contracted hands. (Resident #13) The findings included:	F 312	"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	12/21/16

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	345208	A. BUILDING _____ B. WING _____	C 11/18/2016

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BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 312	Continued From page 8 Resident #13 was admitted to the facility 06/17/03 with diagnosis which included anoxic brain damage, diabetes and rheumatoid arthritis. The current Minimum Data Set (MDS) dated 08/18/16 indicated an assessment of cognitive function was not completed due to deficits. The MDS noted Resident #13 had impairment on both sides of her upper body and required extensive assistance of one staff member for personal hygiene. The current care plan for Resident #13 which was last updated 08/19/16 included the following problem area: Resident #13's (name) "has limited physical mobility and is dependent in activities of daily living (ADL) related to disease process of traumatic brain injury and neurological deficits." Approaches to this problem area included, 1) "Observe resident's skin daily during ADL care and notify nurse if any skin issues are found", 2) "Observe/document/report as needed any signs/symptoms of immobility; contractures forming or worsening, thrombus formation, skin breakdown and fall related injury", 3) Resident's #13 (name) "is dependent for bathing, please check nails and notify nurse if nails need trimming." Skin assessments on the "Skin-Head to Toe Skin Checks" documents from November 2016 included: 11/02/16-Nurse #2 indicated "nails cleaned and trimmed" for Resident #13 11/09/16-Nurse #2 indicated "nails cleaned and trimmed" for Resident #13 11/16/16-Nurse #3 indicated "nails cleaned and trimmed" for Resident #13	F 312	prepared by the provision of Federal and State law." 1. Resident #13 had nails trimmed on 11/17/16. 2. All residents with hand contractures have the potential to be affected by the alleged deficient practice, therefore, Nurse Manager completed fingernail audit on residents with hand contractures on 12/5/16. 3. DON or Nurse Manager will re-educate the licensed nursing staff regarding trimming lengthy nails with specific attention to residents with hand contractures by 12/21/16. Nurse Manager will complete an audit of all residents with hand contractures fingernails 3x/week for 2 weeks, then weekly x2 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by Nurse manager for 3 months at which time the committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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	345208	A. BUILDING _____ B. WING _____	C 11/18/2016

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 312	Continued From page 9	F 312		

Observations of Resident #13 included the following:
11/14/16 4:20 PM Resident #13 was observed in bed, on her back, with her hands resting on her abdomen. Both the right and left wrist and hand of Resident #13 appeared to be severely contracted. The fingers on both hands were drawn in toward her palm and, because of this, the nails were not visible on either hand.
11/15/16 10:10 AM Resident #13 was observed in bed, on her back, with her hands resting on her abdomen. Both the right and left wrist and hand of Resident #13 appeared to be severely contracted. The fingers on both hands were drawn in toward her palm and, because of this, the nails were not visible on either hand.
11/17/16 2:30 PM The OT that worked with Resident #13 from 11/02/15-12/21/15 stated both the right and left hand of Resident #13 were severely contracted.

At the time of the interview on 11/17/16 at 2:30 PM the hands of Resident #13 were observed in the presence of the OT. The OT was able to manipulate the fingers of Resident #13 and noted the following:
Right Hand-The OT noted the nail of the pointer finger extended beyond the end of her finger and the nail was in the palm area of the right hand. When the pointer finger was pulled away an impression where the nail had pressed against the palm area was noted. The OT noted the nail of the middle finger extended beyond the end of her finger and the nail was in the right thumb. When the middle finger was pulled away an impression where the nail had pressed against the right thumb was noted. The OT noted the nail of the right thumb extended beyond the end of

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 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 312	Continued From page 10	F 312		

her finger and rested against the middle finger. When the right thumb was pulled away there was not an impression in the middle finger.
Left Hand-The OT noted the nail of the pointer finger, pinky finger and thumb extended beyond the end of the finger. There was no nail to skin contact observed on the left hand.
The OT stated she did not recall fingernails being so long or an issue when Resident #13 was receiving treatment November 2015-December 2015. The OT stated the nails were of concern, particularly those that left an impression in the resident's hand. The OT stated she had never been asked by staff to assess or assist with nail care but felt it was manageable, especially if 2 people assisted.

On 11/17/16 at 3:10 PM Nurse #2 (facility treatment nurse) looked at the hands of Resident #13 and stated she did see the impression in the area of the right palm and right thumb where the nail of the pointer finger and middle finger had pressed. Nurse #2 stated she was not aware the nails of Resident #13 were so long and noted they did need to be trimmed. Nurse #2 looked at both the right and left hand of Resident #13 and stated all but one nail extended between 1/2"-3/4" beyond the end of her finger and needed to be trimmed. Nurse #2 stated she did not see any skin breakdown in the hands of Resident #13. Nurse #2 stated often times she was asked to assist with nail care, especially for residents that were diabetics. Nurse #2 stated she was dependent on nursing assistants to inform her of any nail care needs for residents and had not been informed of any nail care needs regarding Resident #13. Nurse #2 stated she saw Resident #13 on a daily basis for application of cream to her elbow areas but had not noticed any issues

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 11/18/2016

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 312	Continued From page 11	F 312		

with her nails.

In a follow-up interview on 11/17/16 at 5:00 PM Nurse #2 confirmed she completed the skin assessments for Resident #13 on 11/02/16 and 11/09/16 which noted "nails cleaned and trimmed." Nurse #2 stated she did not visually look at Resident #13's nails when she completed the assessments but asked the nurse on the hall (at the time of the assessment) if there were any issues and none were reported. Nurse #2 noted she was able to trim the nails of Resident #13 without incident (after the observation at 3:10 PM.)

On 11/17/16 at 6:00 PM Nurse #3 stated she completed the weekly skin assessment on Resident #13 on 11/16/16 which indicated "nails cleaned and trimmed." Nurse #3 stated she usually tried to do a visual assessment of a resident when doing a skin assessment and remembered looking at Resident #13 on 11/16/16 and did not recall seeing any concerns with her nails.

On 11/18/16 at 9:13 AM the interim Director of Nursing reported she expected nursing assistants to observe the nails and skin of residents and report any concerns to a nurse. The Director of Nursing noted this was especially important for a resident that had severe contractures, like Resident #13.

On 11/18/16 at 11:15 AM an interview was done with nursing assistant #2 that documented the provision of a shower to Resident #13 on 11/10/16. Nursing assistant #2 stated nail care was done by nursing assistants when showers were given to residents, unless the resident was

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 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 312	Continued From page 12 a diabetic. Nursing assistant #2 stated if a diabetic resident needed nail care she would inform the resident's nurse. Nursing assistant #2 stated she did not recall giving a shower to Resident #13 on 11/10/16 and did not recall any issues with her nails. On 11/18/16 at 11:30 AM Resident #13's physician stated that due to the severity of the contractures of both the right and left hand of Resident #13 it was important to keep nails trimmed to prevent nail to skin contact. On 11/18/16 at 11:45 AM an interview was done with nursing assistant #1 that documented the provision of a shower to Resident #13 on 11/17/16. Nursing assistant #1 stated nail care was done when showers were given to residents. Nursing assistant #1 stated the only exception would be if a resident was a diabetic, then a nurse was informed of the need for nail care. Nursing assistant #1 stated she did provide a shower to Resident #13 on 11/17/16 and did not recall any concerns with the nails on the right and left hand of Resident #13 when the shower was given.	F 312		
F 323 SS=E	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.	F 323		12/21/16

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 11/18/2016

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the handrail connectors were in good repair and without sharp edges for 1 of 2 hallways. (West Wing hallway - Memory Care Unit). The findings included: During an initial tour of the West Wing hallway on the Memory Care Unit (MCU) on 11/14/16 at 10:45 AM the following was observed: A. between the exit door for the stairwell and room 307 three of three plastic wall mount handrail connectors were broken with jagged edges B. between the elevator and room 306 one of six plastic wall mount handrail connectors was broken with jagged edges C. between room 305 and room 306 three of three plastic wall mount handrail connectors were broken with jagged edges D. between room 304 and room 302 two of eight plastic wall mount handrail connectors were broken with jagged edges E. between room 303 and the medication storage room three of three plastic wall mount handrail connectors were broken with jagged edges F. between room 302 and the clean linen room one of four plastic wall mount handrail connectors was broken with jagged edges	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 by the provision of Federal and State law." 1. All broken handrail connectors on West Wing were repaired. 2. All residents have the potential of being affected by the alleged deficient practice. Administrator or Department Manager will educate all staff on checking safety of handrails and reporting procedures. 3. Maintenance Director or Maintenance Assistant will audit all handrails and handrail connectors in facility weekly x4 weeks and every 2 weeks/2 months to verify compliance. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the Maintenance Director monthly x3 months. The QAPI committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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 11/18/2016

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BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 323	Continued From page 14	F 323		

G. between the supply closet and the medication storage room one of three plastic wall mount handrail connectors was broken with jagged edges

On 11/18/16 at 12:39 PM three residents were observed walking down the West Wing hallway on the MCU holding onto the handrails.

A second observation of the West Wing hallway on the MCU on 11/18/16 at 12:40 PM revealed the same observations of the hallway's handrails that were present on 11/14/16 at 10:45 AM.

During an interview on the West Wing hallway on the MCU with Housekeeper #1 (H #1) on 11/18/16 at 12:42 PM, H #1 stated if she saw anything that needed to be fixed she would let them know immediately in maintenance or let someone in nursing know. H #1 was not aware of anything on the West Wing hallway on the MCU that needed to be fixed.

During an interview on the West Wing hallway on the MCU with Nurse Aide #1 (NA #1) on 11/18/16 at 12:51 PM, NA #1 stated if he saw anything that might be harmful to a resident he would remove the resident from the situation and report it immediately to his nurse.

During a walking tour on the West Wing hallway on the MCU with the Administrator (ADM) and Maintenance Director (MD) on 11/18/16 at 1:13 PM, the ADM and DM both acknowledged they were unaware of any problems with the wall connectors. The MD stated they check the handrails for loose connections once a week but he was unaware of the broken wall connectors.

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	345208	A. BUILDING _____ B. WING _____	C 11/18/2016

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F 323	Continued From page 15 The ADM stated her expectation was for the handrails to be safe and secured against the wall and the wall connectors to be free from any hazardous edges.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to properly label and seal 10 bags of frozen foods kept in the freezer to preserve nutritive integrity and palatability. The findings included: During a tour of the facility kitchen on 11/14/16 at 10:38 AM the dry food storage area, freezer and refrigerators were observed and food preparation equipment was inspected. The Food Service Director (FSD) was present during the observations. On 11/14/16 at 10:38 AM the freezer was inspected. The following foods observed in the freezer were opened, unsealed, undated with frost were as follows:	F 371	"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 by the provision of Federal and State law." 1. The freezer food storage was corrected immediately as observed by the Dietary manager and the Administrator. 2. All residents have the potential to be affected by the alleged deficient practice; therefore, all dietary staff were re-educated by Dietary Manager regarding proper storage of food in the	12/21/16

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F 371	Continued From page 16 1. 3 cartons with unsealed bags of unbaked cookies. 2. 1 partial package of hot dogs wrapped in clear plastic wrap, but not labeled. 3. 1 carton containing one unsealed undated bag of partially used corn. 4. 1 carton containing one unsealed undated bag of partially used French fries. 5. 1 carton containing one unsealed undated bag of partially used mixed vegetables. 6. 1 carton containing one unsealed undated bag of partially used okra. 7. 1 carton containing one unsealed undated bag of partially used squash. 8. 1 carton containing one unsealed undated bag of partially used hash brown patties in a carton labelled Tator Tots. 9. One broken bag of strawberries with dried up strawberries and frosted labeled 5/19/16. On 11/18/16 at 9:01 AM the Food Service Director (FSD) was interviewed. The FSD stated he was not aware the items in the freezer were opened, not sealed and not dated until this time of the observations. FSD provided a freezer storage chart and a policy and procedure document which indicated foods frozen below 0 degrees should be overwrapped and sealed in their original carton can be kept longer than 2 months, and be tightly sealed to prevent freezer burn of foods. The FSD verified the bags of frozen foods were not sealed and not labeled. The FSD confirmed it was his expectation that foods in refrigerators, freezers and dry storage should be resealed and dated when they were opened. On 11/18/16 at 1:01 PM the administrator was	F 371	freezer. 3. The Dietary manager will monitor storage of food in the freezer 5 days/week x4 weeks then 3 days/week x2 months to ensure food is sealed properly and dated. The Administrator/Department Manager will observe the storage of food in the kitchen freezer 3 days/week x 4 weeks and then once weekly x2 months to verify compliance. Any storage issues will be addressed immediately. 4. Date obtained during the audit process will be analyzed for patterns and/or trends and reported to the QAPI committee by the Dietary manager monthly x 3 months. The QAPI committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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 11/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 371	Continued From page 17 interviewed. The Administrator stated it was her expectation that packaged food items in all storage areas including the refrigerators, freezer and dry storage were dated, labeled, and securely closed after they were opened.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		12/21/16

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BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 441	Continued From page 18 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to correctly disinfect a blood glucose meter after use for 1 of 1 resident during observation of obtaining a finger stick blood sugar (Resident #132). The findings included: A review of the facility policy entitled Glucometer (blood glucose meter) Decontamination revised 09/15 indicated the following procedure for disinfecting the glucometer: A. After performing the glucometer testing, the nurse shall perform hand hygiene, don gloves, and use the disinfectant wipe to clean all external parts of the glucometer. A specific amount of wet contact time is not required for cleaning. B. Gloves shall be removed, hand hygiene performed, and clean gloves shall be donned. C. A second wipe shall be used to disinfect the glucometer, allowing the meter to remain wet for the contact time required by the disinfectant label. (3 minutes with blue) D. The clean glucometer will be placed on another paper towel. E. Gloves will be removed and hand hygiene performed. F. The glucometer will be placed in the appropriate storage location until needed. Resident #132 was admitted to the facility	F 441	"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 by the provision of Federal and State law." 1. Resident #132 was not negatively affected. The glucometer was cleaned and the container disinfected per policy immediately. 2. All residents receiving blood glucose monitoring have the potential to be affected by the alleged deficient practice; therefore, Nurse #1 was educated 11/16/16 by the Director of Nursing regarding SAVA's policy for decontaminating the glucometers. The DON/Nurse Manager will re-educate all nurses on the policy and process for cleaning and disinfecting glucometers. 3. Nurse Managers will observe/audit blood glucose monitoring of 2 residents per unit/week x4 weeks, then 2 residents per unit every other week x2 months to ensure nurses are following the	

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	345208	A. BUILDING _____ B. WING _____	C 11/18/2016

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F 441	Continued From page 19 10/24/16 with diagnoses which included diabetes mellitus. During an observation on 11/16/16 at 4:23 PM, Nurse #1 (N #1) was obtaining a finger stick blood sugar for Resident #132 using a shared glucometer for all residents on the hall requiring finger stick blood sugar levels. Following the procedure, N #1 returned the uncleaned blood glucose meter to a plastic storage box, closed the storage box, removed her gloves and threw them away. When asked, N #1 stated she was done and when asked if she forgot to do anything she stated she had forgotten to clean the blood glucose meter because she was nervous. N #1 then removed the blood glucose meter from the plastic storage box while ungloved, cleaned it with an alcohol swab for 45 seconds, and returned it to the plastic storage box. The plastic storage box contained the Glucometer Decontamination policy and procedure for the facility. Upon review of the policy and procedure for Glucometer Decontamination, N #1 verified she had not cleaned the blood glucose meter correctly. An interview was conducted with the Unit Coordinator (UC) on 11/17/16 at 8:12 AM. The UC stated there was a printed guideline for the Clorox wipes to be used for 3 minutes where the glucometer was visibly wet. The UC stated his expectations were for anyone checking blood glucose levels to follow the guidelines for properly disinfecting the glucometers. An interview was conducted with the Director of Nursing (DON) on 11/17/16 at 8:24 AM. The DON stated her expectation was for all nurses that use the glucometer to follow the federal guidelines for the facility to ensure reusable equipment is cleaned and disinfected and they would prevent any indirect transmission of infections.	F 441	decontamination policy for glucometers. Any variation form the policy will be corrected immediately. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to the QAPI committee by the DON monthly for 3 months. The QAPI committee will evaluate the effectiveness of the interventions and determine if further auditing is needed.	

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BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

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F 520	Continued From page 20	F 520		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in October 2015. This was for one recited deficiency originally cited in October 2015 on an annual recertification survey and subsequently recited on the current recertification survey. The deficiency was in the	F 520	"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 by the provision of Federal and State law."	12/21/16

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 11/18/2016

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F 520	Continued From page 21 area of kitchen sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: This tag is cross referred to: F 371: Based on observations and staff interview the facility failed to properly label and seal 10 bags of frozen foods kept in the freezer to preserve nutritive integrity and palatability. In October 2015 the facility was cited for F 371 for failure to address concerns with the final rinse temperature of the dish machine and failed to clean the ice scoop holder and fans in the kitchen. On 11/18/16 at 2:30 PM the Administrator was interviewed and stated the facility had a Quality Improvement Committee that met monthly to discuss, identify and review areas for improvement. The Administrator reported that Committee had an ongoing performance improvement concern related to kitchen sanitation because of the facility's history with a citation. The Administrator stated an ongoing monthly inspection of the kitchen was done along with the Food Service Director and District Managernd and no concerns related to kitchen sanitation had been identified.	F 520	1. Education has been provided for Administrator by the District Director of clinical on 11/21/16. Education included SAVA's Quality Assurance and Performance Improvement Program and the expectations associated with the program. 2. All residents have the potential to be affected. QAPI committee is reviewing weekly the plans of correction and action items related to the reciting of F371. Plans of correction accompany the CMS-2567. 3. Education was provided 11/21/16 for the QAPI committee members regarding the responsibilities of the QAPI committee to ensure sustainability with identified areas of opportunity. QAPI meetings are being held weekly for 4 weeks and include discussion of the deficient tags cited while addressing the plans of correction. 4. The Administrator will send the weekly QAPI meeting minutes to the District Director of Operations and District Director of Clinical for review and recommendations. The Administrator and DON will analyze the data obtained, and report patterns/trends to the QAPI committee monthly x 3 moths. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on outcomes identified to ensure continued compliance.	