

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/23/2012
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	
(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=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of medical records and facility records, the facility failed to supervise and put fall risk interventions in place to prevent falls, including a chair alarm and non-skid floor strips, for 1 of 3 sampled residents with a history of falls. (Resident #3)</p> <p>The findings are: Resident #3 was admitted to the facility in 2009. Diagnoses included Dementia, Osteoporosis, shoulder joint pain and back disorder.</p> <p>Care area assessments dated 8/29/11 summarized that Resident #3 was unsteady with walking/turning around, required human assistance when moving from a seated to a standing position, moving on/off toilet and surface/surface transfers, oriented to herself, but not to place, situation or time.</p> <p>A quarterly minimum data set dated 2/28/12, assessed Resident #3 with impaired short and long-term memory, use of a wheel chair for mobility, requiring limited assistance of one staff</p>	F 323	<p>F 323</p> <p>1) Corrective action has been achieved for the alleged deficient practice in regards to Resident #3. Resident #3 has a Physician order for floor strips to be put into place as well as a chair alarm while in chair. Care plan was updated on 01/25/2012 with the intervention of nonskid floor strips. Care plan was updated on 04/26/2012 for the chair alarm to be in place while in chair. Both nonskid floor strips and Chair alarm was placed on residents chair on 05/23/2012. The Director of Nursing, Staff Development Coordinator and Unit Managers educated direct care staff regarding use of Nursing Assistant assignment sheet in order to provide care and safety for the residents.</p> <p>2) Residents who are at risk for falls and utilize body alarms to alert staff has the potential to be affected by the same alleged deficient practice. The Director of Nursing (DON)/Staff Development Coordinator (SDC)/RN supervisor completed an audit on 05/29/2012, to identify residents that have Physician orders for body alarms and other interventions to</p> <p>" 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."</p>	6-15-2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jana Meler Administrator 6/18/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Original signature 6/14/12 nh



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F 323	<p>Continued From page 1</p> <p>for bed mobility, transfers and locomotion on the unit and one fall without injury since the prior assessment.</p> <p>A care plan last updated 5/1/12 recorded that Resident #3 was at risk for falls related to her mental status, osteoporosis, history of previous falls, and balance problems with walking. Interventions included non-skid socks, non-skid floor strips, Falling Star program (routine monitoring), and to offer/assist to the toilet frequently/as accepted via the Custom Catch program.</p> <p>Review of nurse's notes in the medical record and incident reports revealed that Resident #3 had the following falls. On 1/25/12 at 5:45 AM, Resident #3 was found seated on the floor between the bed and bathroom door without shoes/socks and wearing a gown that was wet. She ambulated to the toilet independently; there was no injury. Interventions after this fall included to place Resident #3 on the Custom Catch program, staff to place non-skid socks to her feet and non-skid strips to the floor.</p> <p>On 3/16/12 Resident #3 changed rooms.</p> <p>On 3/31/12 at 11:00 PM, Resident #3 was found seated on the floor next to her bed. She tripped over her wheel chair. There was no injury and the Resident was referred to therapy. Non-skid floor strips were not in place at the time of this fall.</p> <p>On 4/26/12 at 3:00 PM, Resident #3 was found seated on the floor next to her bed with a pillow and a doll on the floor. She fell from her bed. She complained of left hip pain. An x ray of her left hip</p>	F 323	<p>prevent/reduce the risk of falls. Care plans and nursing assistant assignment sheets were updated to reflect the residents' needs for body alarms and or other interventions. The Interdisciplinary team will review Incident/Accident reports and Physician orders during morning meeting Monday through Friday to identify the need for body alarms or new orders for body alarms or other said interventions, update care plans and nursing assistant assignment sheets. Weekend RN supervisor will review incident reports and physician orders on Saturday and Sunday, and update care plans and nursing assistant assignment sheets with interventions as ordered.</p> <p>3) Monitors put into place to ensure the alleged deficient practice does not recur include: The Staff Development Nurse (SDC) and Director of Nursing (DON) provided in service education beginning 05/23/2012 for the nursing, therapy, dietary, housekeeping staff and department managers regarding "Use of Nursing Assistant assignment sheets to assure resident receives the appropriate care and safety devices." The SDC will in service new hires during orientation and at least</p> <p>" 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."</p>	

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F 323	<p>Continued From page 2</p> <p>was taken and was negative for fracture. Non-skid floor strips were not in place at the time of this fall.</p> <p>On 5/1/12 at 3:45 AM, Resident #3 fell from her bed onto the floor with complaints of back pain. A clutter-free bed was an intervention that added after this fall. Non-skid floor strips were not in place at the time of this fall.</p> <p>On 5/22/12 at 4:45 PM Resident #3 was found on the floor in the bathroom with complaints of pain to her back and right side; she was transferred to the emergency room for evaluation and returned with no new physician's orders. A wheel chair alarm was not in place at the time of this fall.</p> <p>Resident #3 was observed on 5/23/12 at 8:23 AM in her room seated in her wheel chair. Licensed nurse #1 provided the Resident with her morning medications and left the room. Additionally on 5/23/12 at 9:45 AM, Resident #3 was observed in her room seated in her wheel chair. A wheel chair alarm and non-skid floor strips were not in place during these observations.</p> <p>An interview on 5/23/12 at 11:10 AM with nursing assistant #1 (NA #1) revealed she routinely worked with Resident #3 on the 7AM - 3PM shift. She stated that the Resident required assistance with toileting and that she used a gait belt to transfer Resident #3 to the toilet every two hours.</p> <p>On 5/23/12 at 11:30 AM Resident #3 was in her room seated in her wheel chair and at 1:05 PM and 2:15 PM, Resident #3 was observed lying in her bed. A wheel chair alarm and non-skid floor strips were not observed in place during these</p>	F 323	<p>quarterly. The Interdisciplinary team (IDT) will review Incident/Accident reports and Physician orders during morning meeting Monday through Friday to identify need for body alarms or new orders for body alarms. The IDT team will update care plan and nursing assistant assignment sheets daily according to new orders. The Fall Risk Assessment will be conducted upon admission, quarterly, annually and significant change. RN supervisor will review incident reports and physician orders on a daily basis and Weekend RN supervisor will review incident reports and physician orders on Saturday and Sunday, and update care plans and nursing assistant assignment sheets with interventions as ordered. The Charge Nurse/RN supervisor will communicate the need for body alarm to the direct care staff via the Nursing Assistant assignment sheet. The IDT will conduct facility rounds at least daily Monday through Friday for four weeks, then weekly thereafter to identify additional training needs and to ensure implementation of care plan interventions to minimize the risk for falls.</p> <p>" 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."</p>	

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F 323	<p>Continued From page 3 observations.</p> <p>During a follow-up interview on 5/23/12 at 2:55 PM, NA #1 stated that she tried to keep Resident #3 in a safe place in the hallway as much as the Resident would tolerate for monitoring because Resident #3 would often self propel in the hallway. NA #1 pulled out a resident care guide at the time of the interview and stated (referring to the guide) that Resident #3 could stand, ambulate to the bathroom with staff/gait belt assistance and that the Resident was to be kept in a highly visible area out of her room because of her risk for falls. NA #1 further stated that she tried to monitor and check on Resident #3 often for toileting because the Resident had fallen in the past attempting to go to the bathroom alone. The resident care guide also documented non-skid socks and floor strips as interventions, but did not document a tabs monitor to the wheel chair. NA #1 was not aware that Resident #3 was to have a tabs alarm to her wheel chair when the Resident was out of her bed to her chair.</p> <p>During an interview on 5/23/12 at 3:46 PM with the director of nursing (DON), she stated that she was responsible for reviewing the incident report for completeness/accuracy after an incident occurred. The inter-departmental team (IDT) made up of department managers, met after each incident and discussed any interventions that were needed. Review of the falls for Resident #3 during this interview revealed that after the fall on 1/25/12, the IDT implemented non-skid socks and non-skid floor strips next to the bed. After the fall on 4/26/12, a tabs alarm to her wheel chair was implemented as a fall intervention. The IDT had not yet met to discuss possible fall</p>	F 323	<p>QAA:</p> <p>4) The Administrator/DON will review documentation of observations; incidents/accidents as well as IDT round data and identify patterns or trends and report trends in Quality Assessment and Assurance (QAA) Committee weekly for four weeks then monthly thereafter. The QAA Committee will evaluate the effectiveness of the above plan and adjust the plan based on trends identified.</p> <p>Date of alleged compliance: 06/15/2012</p> <p>" 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."</p>	

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F 323	<p>Continued From page 4</p> <p>interventions after the Resident fell on 5/22/12. The DON stated that after an incident, interventions were communicated verbally to the nursing staff and added to the resident care guide. A request to place non-skid floor strips would be communicated to maintenance during the IDT meeting.</p> <p>An interview on 5/23/12 at 4:30 PM with licensed nurse #2 revealed she was the 3PM - 11PM nurse for Resident #3. LN #2 stated she did remember seeing a tabs alarm to the Resident 's wheel chair at times in the past, but she was not certain if the alarm was a current fall risk intervention.</p> <p>An interview on 5/23/12 at 4:45 PM with LN #1 revealed Resident #1 did not have a tabs monitor to her wheel chair as a current intervention for falls. LN #1 stated that she monitored the Resident routinely during shift for safety, but to her knowledge the Resident did not have a chair alarm or non-skid strips to the floor in her room.</p> <p>A follow-up interview and observation on 5/23/12 at 5:00 PM of Resident #3's room with the DON and maintenance director present confirmed that non-skid floor strips had not been placed to the floor at bedside after Resident #3 changed rooms on 3/16/12. The DON also stated that the alarm to the wheel chair should be placed and attached to the resident when she was out of bed to her wheel chair.</p> <p>An interview on 5/23/12 at 5:30 PM with NA #2 revealed she found Resident #3 on the floor in the bathroom doorway to the adjacent room. The Resident's wheel chair was next to the toilet.</p>	F 323	<p>" 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."</p>	

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F 323	Continued From page 5 Resident #3 self propelled to the bathroom and transferred herself to the toilet. NA #2 stated that Resident #3 routinely went back and forth to the bathroom and because of that her bathroom door was left open for the Resident to go back and forth. NA #2 stated that a tabs monitor was not in place to the Resident's wheel chair at the time of this fall, because sometimes "we can't find it."	F 323			