STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 07/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and medical record review, the facility failed to provide snacks at bedtime daily for 4 of 4 residents (Residents #8, #10, #11 and #13). The findings included: 1a. Resident #8 was admitted to the facility on 10/04/14 with diagnoses that included diabetes, thyroid disorder, anxiety and depression. The annual Minimum Data Set (MDS) dated 04/05/16 indicated Resident #8 required supervision with eating. The MDS further indicated Resident #8 was alert and oriented with no memory impairment. The MDS also indicated it was very important to Resident #8 to have snacks available between meals. During an interview with Resident #8 on 07/07/16	F 368	1) Resident #8, #10, #11, and #13 has had no adverse outcome related to the deficient practice. 2) Education provided by the SDC to the nursing staff on offering and providing HS snacks to the residents by 08/01/2016. 3) Unit Managers and/or designee will audit clinical records to ensure HS snacks are being offered/provided every HS. Audits will be performed five times per week for four weeks and then three times per week for two months. Results will be reported at the QAPI for review.	8/1/16

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

Electronically Signed | 07/29/2016

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F 368	Continued From page 1 at 4:16 PM, Resident #8 stated she is never offered an evening snack. Resident #8 also stated activities sometimes offers snacks during the day around 3:30 PM or so. Resident #8 stated she had never been offered a snack at night and she did not go to bed until around 11:00 PM. 1b. Resident #10 was admitted to the facility on 11/11/14 with diagnoses that included diabetes, constipation, non-Alzheimer's dementia, and depression. The annual MDS dated 09/23/15 indicated Resident #10 required supervision with eating. The MDS further indicated Resident #10 did have some memory impairment. The MDS also indicated it was very important to Resident #10 to have snacks available between meals. During an interview with Resident #10 on 07/08/16 at 9:35 AM, Resident #10 stated he is offered a snack once or twice a month. Resident #10 also stated he would not want a snack every day but would like the opportunity to have a snack a few nights a week but it was not offered to him. 1c. Resident #11 was admitted to the facility on 10/01/15 with diagnoses that included diabetes, thyroid disorder, and depression. The 5-day admission MDS indicated Resident #11 required limited assistance with eating. The MDS further indicated Resident #11 was alert and oriented with no memory impairment. The MDS also indicated it was very important to Resident #11 to have snacks available between meals. During an interview with Resident #11 on 07/08/16 at 9:41 AM, Resident #11 stated she was no longer offered snacks at night since her therapy days were completed. Resident #11 stated since she had to move to a different hall when her therapy ended and she was no longer being offered an evening snack, but would like to have a snack most nights.	F 368	4) The Administrator and Director of Nursing will analyze the data obtained and report patterns/trends to the QAPI monthly for three months.	

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F 368	Continued From page 2	F 368		

1d. Resident #13 was admitted to the facility on 06/13/16 with diagnoses that included lupus, fibromyalgia, depression, and obesity. The admission MDS indicated Resident #13 required supervision with eating. The MDS further indicated Resident #13 was alert and oriented with no memory impairment. The MDS also indicated it was very important to Resident #13 to have snacks available between meals.
During an interview with Resident #13 on 07/08/16 at 3:15 PM, Resident #13 stated she was offered ice cream or a beverage 2 or 3 times a week at night, but they did not offer it every night. Resident #13 stated she would like to have the option of receiving a snack every night.
During an interview with the Dietary Manager (DM) on 07/07/16 at 3:30 PM, the DM stated dietary staff brought snacks to the units at 10:00 AM, 2:00 PM, and in the evening. An observation of the nourishment room revealed there was a variety box of cookies/crackers in the cabinet and the refrigerator had applesauce and milk/juice. The DM further stated the dietary staff stocked the nourishment room daily and ensured snacks were available. The DM stated all residents were offered evening snacks by nursing staff, not by dietary staff.

During an interview with Nurse Aide #1 (NA #1) on 07/07/16 at 5:30 PM, NA #1 stated she brought residents snacks at night if they ask for it, but snacks were not offered to everyone. NA #1 also stated activities brings a cart around in the afternoon and offered the resident a snack before dinner, but the nurse aides did not bring a cart around and offer snacks at night.
During an interview with Nurse Aide #2 (NA #2) on 07/08/16 at 3:39 PM. NA #2 stated the NA's bring an ice cart on the hall before dinner, but not

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F 368	Continued From page 3 a snack cart. NA #2 also stated sometimes she offered snacks in the evening, but not every time she works. NA #2 further stated when she was the only NA on the hall, she made taking care of the residents a priority, and it took the entire shift to provide the care and giving out snacks was not a priority. During an interview with the Director of Nursing (DON) on 07/08/16 at 4:20 PM, the DON stated that snacks come out during the day and they come out regularly. She also stated when she was present in the facility the snacks were being passed. The DON acknowledged it was her expectation snacks would be offered to all residents in the evening.	F 368		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews the facility failed to document in the medical record the administration of	F 514	1) Resident #1 is no longer a resident of the facility.	8/1/16

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F 514	Continued From page 4 medication for 1 of 7 residents reviewed for pharmacy services and an assessment of a bruised, fractured wrist for 1 of 8 sampled residents reviewed for a change in condition (Resident #1). The findings included: 1. Resident #1 was admitted to the facility on 12/05/15 and discharged on 03/08/16. Her diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, and peripheral vascular disease. Review of Resident #1's care plans dated 12/18/15 revealed she had altered respiratory status with difficulty in breathing related to COPD. The goal was for Resident #1 to be free of signs and symptoms of poor oxygen absorption through the next review date. Interventions included administering medications as ordered; and monitoring, documenting, and reporting to physician as needed for signs and symptoms of respiratory distress. Review of Resident #1's medical records indicated that she was on 6 different inhalers for her COPD in February, 2016. Review of Resident #1's Medication Administration Record (MAR) revealed that the nurse who administered medication to Resident #1 at the first shift failed to complete twenty-seven of the MAR entries on 02/22/16. The columns were completely blank without the nurse's initials and the chart codes. A review of the progress notes from 02/18/16 to 02/24/16 revealed no entries related to Resident #1's medication administration were charted. Review of the resident sign-out log revealed that Resident #1 was signed out of the facility on 02/22/16 at 3:20 PM. However, the scheduled medications that were supposed to be administered at 9:00 AM that morning were not charted in the MAR. Review of facility staffing log	F 514	2) All residents have the potential to be affected by this deficient practice, therefore an audit was conducted by the SDC and the Director of Nursing on the last 30 days of incident reports to ensure clinical documentation was in the resident's medical records. Education will be provided by the Director of Nursing and Unit Managers for Licensed Nurses by 08/01/2016 regarding required nursing documentation as it relates to a resident's change in condition and medication administration. 3) Resident's with condition changes will be reviewed by nursing. Unit Managers will audit those residents who have had condition changes to ensure nursing documentation has been completed. Unit Managers will audit Medication Administration Records to ensure documentation has been completed. Audits will be performed five times a week for four weeks and then three times per week for two months. Results will be reported to the QAPI Committee for review. 4) Administrator and Director of Nursing will analyze data obtained and report trends to the QAPI Committee monthly for three months.	

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for the first shift of 02/22/16 revealed Resident #1 was under the care of Nurse #1; she was on duty from 7:00 AM to 3:00 PM that day.
An interview was conducted on 07/08/2016 at 11:52 AM. Nurse #1 confirmed she had administered all the medication to Resident #1 as ordered on 02/22/16 morning. Since Resident #1 was not in her room that morning, she had to look for Resident #1 in order to administer medication. Nurse #1 stated she got distracted and forgot to chart the medication administration later.
In an interview with Directing of Nursing (DON) on 07/08/2016 at 3:17 PM, she stated it was her expectation for all the entries in MAR to be filled regardless if the medications were administered to the resident or not. If the medications were not administered, the nurse had to initial and chart the reason for not administrating the medications. According to the DON, it was unacceptable for any nurse to just leave a "blank" in the MAR.

2. Resident #1 was admitted to the facility on 12/05/15 with diagnoses that included high blood pressure, chronic lung disease, tremors, and frequent pain. The admission Minimum Data Set (MDS) dated 12/11/15 indicated Resident #1 required extensive assistance with bed mobility, transfers, toileting and limited assistance with dressing and hygiene. The MDS also indicated she took scheduled pain medication.
Review of nurse's notes for January 2016, indicated Resident #1 reported to Nurse #1 that she was in the bathroom and lost her balance, hitting her right wrist on the wall when she tried to brace herself. Resident #1 reported that she did not fall but wanted to report the incident. Resident #1 also stated the incident occurred at 5:00 PM on 01/22/16.

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During an interview with Nurse #1 on 07/07/16 at 3:08 PM, Nurse #1 indicated Resident #1 did report she had bumped into the wall trying to get her balance and initially it did not look like she had injured her wrist. Nurse #1 indicated Resident #1 had no bruising and was able to move her fingers and hand without pain. Nurse #1 made a late entry note on 01/26/16 describing this incident that occurred on 01/22/16.
During an interview with Nurse #4 on 07/08/16 at 2:05 PM, Nurse #2 stated she remembered Resident #1 had come to the nurse's desk and stated that her wrist was hurting. Resident #1 showed Nurse #2 her wrist and Nurse #2 stated she remembers looking at it and it was "pretty bruised." Nurse #2 stated she reported this to the Nurse Practitioner (NP) who was in the facility at the time and the NP looked at Resident #1's wrist and ordered an x-ray. In review of the physician's orders there was not an order for an x-ray. Nurse's notes also indicated no documentation about resident's wrist. Nurse #2 stated she did not document any of this because she thought her primary nurse knew about it and would follow up on it. Nurse #2 acknowledged she should have documented her findings herself or made sure the primary nurse for Resident #1 would have made a nurse's note about her wrist.

Review of doctor's progress notes indicated Resident #1 was seen on 1/25/16 to evaluate a right wrist injury. The progress notes indicated the resident reported her wrist had been painful since the injury and was noted to have mild edema with limited range of motion due to pain and a weak hand grasp. The progress notes further indicated there was an x-ray pending. The radiology report dated for 01/25/16 for Resident #1 indicated there was an x-ray of her

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F 514	Continued From page 7 wrist on that indicated a right radial fracture. Review of doctor's progress notes indicated Resident #1 was seen again on 01/26/16 as a follow-up to her "right wrist injury 1/22/16." The progress notes indicated she had mid-point tenderness, slight edema, limited range of motion, but her pulses were intact in her wrist. During an interview with the Director of Nursing (DON) on 07/08/16 at 4:20 PM, the DON acknowledged her expectation was for all information about a resident that needed to be documented would be present in the chart.	F 514		
F 520 SS=D	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	F 520		8/1/16

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F 520	Continued From page 8 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in August 2015. This was for one recited deficiency which was originally cited in July 2015 on a recertification survey and complaint investigation and again on the current complaint investigation. The deficiency was in the area of administration regarding accuracy of the medical record. The facility's continued failure to implement and maintain procedures from a QAA Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 514: Medical Record Accurate and Complete: Based on medical record review, resident and staff interviews the facility failed to document in the medical record the administration of medication for 1 of 7 residents reviewed for pharmacy services and an assessment of a bruised, fractured wrist for 1 of 8 sampled residents reviewed for a change in condition (Resident #1). During the July 2015 recertification survey and complaint investigation, the facility was cited for failure to document the time of a resident's fall/fracture, the time a nurse's note was written,	F 520	1) Education has been provided for the Administrator by the DDCS on 07/19/2016. 2) QAPI Committee has reviewed the meeting minutes for the past three months to identify trends and ensure actions have been completed as it relates to the previous cited tag F514. Quality Assurance monitoring of this area will be completed as specified in the POC related to the reciting of F514. 3) Education was provided on 07/19/2016 for the QAPI Committee Members regarding the purpose of the QAPI Committee Meeting and their responsibilities as QAPI Members. 4) QAPI will be held weekly for four weeks then monthly to discuss the deficiencies cited and the plan of care. The Administrator will send QAPI Meeting Minutes weekly for four weeks to the DDO and DDCS for review and recommendations. The Administrator and Director of Nursing will analyze the data obtained and report patterns and trends to the QAPI Committee monthly for three months.	

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F 520	Continued From page 9 time of a nurse practitioner's assessment, time of a transfer to the hospital and the severity/location of pain and effectiveness of pain medication for a resident who sustained a fractured hip after a fall. During a telephone interview with the administrator on 07/11/16 at 07:45 AM he stated that he had been the administrator since June 2016 and he coordinated the facility's QAA committee. He stated he was not the administrator at the time of the facility's recertification survey in July 2015 and could not say why there was a repeat deficiency regarding accurate and complete documentation in the medical record. He stated that he had not looked at that issue in the short time he had been the administrator and his first QAA meeting was planned for later that month.	F 520		