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

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 04/19/2018

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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	"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 plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: a.) On 4/18/2018 DON validated the incident report on Resident #2 from fall on 3/24/18 did not include notification of Hospice. b.) On 4/18/18 DON validated the SBAR for Resident #2 did not state Hospice had been notified c.) On 4/18/18 DON validated the care plan for Resident #2 stated to notify Hospice of falls. d.) Facility employs temporary licensed staff and LPN did not have proper knowledge of contacting hospice for a fall. 2.) The procedure for implementing the acceptable plan of correction for the specific deficiency cited: a.) Resident #2 has expired b.) In-Service licensed staff on notification of any change of condition for residents on hospice. c.) Hospice notification process was updated to reflect notification of changes of condition which includes falls.	5-17-18

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

Electronically Signed DM Kelley Administrator 5/9/18

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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and Hospice staff interview the facility failed to follow the care plan by contacting Hospice after a resident's fall for 1 of 3 residents sampled for accidents (Resident #2). Findings included: Resident #2 was admitted on 10/18/17 with diagnoses including Alzheimer's disease among others. The significant change Minimum Data Set (MDS) dated 02/17/18 indicated Resident #2 had severely cognitively impaired and required extensive to total assistance with her activities of daily living. The MDS also indicated Resident #2 had less than 6 months to live. Record review of the care plan for falls with initial date of 10/19/17 indicated Resident #2 was at risk for falls related to confusion, gait and balance problems, and being unaware of safety needs. An intervention/task regarding falls initiated on 02/23/18 was to "notify Hospice of any falls." Record review of the incident/accident report revealed Resident #2 had a fall on 3/24/18. A description of the incident indicated Resident #2 "rolled out of bed onto floor" with a resulting "bruise/hematoma" on her forehead. The accident/incident report also revealed a family member/resident representative and the Family Nurse Practitioner (FNP) for the facility had been notified, but no other notification was noted.	F 656	3.) The monitoring procedure to ensure The acceptable plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory compliance: a.) DON/UM will audit Hospice Resident SBAR's 5 days a week for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 4 weeks to ensure that notification of Hospice has occurred with SBAR's of Hospice Residents. b.) DON/UM will report finding of the Audits monthly to QAPI monthly x3 months for review and revision of Audit. 4.) The title of the person responsible for Implementing the acceptable plan of Correction: The Director of Nursing (DON) and/or Unit Manager (UM) will be responsible for the implementation of the acceptable plan of correction. 5.) Dates when corrective action will be Completed: May 17, 2018	

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F 656	Continued From page 2 Record review of nurses' notes for 03/24/18 - 04/17/18, SBAR (physician notification tool), incident/accident report or Hospice notes indicated Hospice had not been notified of Resident #2's fall on 3/24/18. During an interview with the Unit Manager (UM) on 04/19/18 at 1:49 PM, the UM stated when Resident #2 had the fall on 3/24/18, it occurred on a weekend when agency staff was present and they were probably unaware of the protocol for contacting Hospice. During an interview with the MDS Coordinator (MDS-C) on 04/19/18 at 2:24 PM, the MDS-C stated she puts an approach on the care plan for staff to notify Hospice in the event of a fall for all Hospice residents including Resident #2. During an interview with a Hospice Representative (HR) on 04/19/18 at 2:58 PM, the HR reviewed Hospice records for Resident #2 and verified they were not notified until another HR was in the facility on 03/26/18 and was informed of the fall by the UM. During an interview with the Administrator on 04/19/18 at 4:19 PM, the Administrator stated her expectation was for the care plan to be followed. During an interview with the Director of Nursing (DON) on 04/19/18 at 4:24 PM, the DON stated her expectation was for the nurses to follow the care plan.	F 656		