STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 12/10/2021

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BRIAN CENTER HEALTH & RETIREMENT CLAYTON	204 DAIRY ROAD CLAYTON, NC 27520

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F 000	INITIAL COMMENTS An on-site complaint survey was conducted on 12/8/21. The survey was extended to 12/10/21 for the collection of additional information. The exit date was 12/10/21. One (1) of 1 complaint allegation was substantiated resulting in a deficiency at F689.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and resident ' s family interviews, and facility and hospital record reviews, the facility failed to provide staff supervision while toileting 1 of 3 residents reviewed for accidents (Resident #1), resulting in a fall. This occurred for a resident assessed to have impaired cognitive status, poor safety awareness, and need for assistance with toileting. The findings included: Resident #1 was admitted to the facility on 9/21/21 for rehabilitation following a hospitalization for pneumonia. Her cumulative diagnoses included mild cognitive impairment, generalized muscle weakness, dizziness, and a history of repeated falls.	F 689	F 689 Free of accident hazards/Supervisions, Devices Resident #1 had a successful planned and safe discharge from the facility on 10/13/2021. All residents that have impaired cognitive status with poor safety awareness, and require assistance with toileting are at risk for falls if not supervised. A review of residents that have fallen for the last 30 days was conducted by the Director of Nursing on 12/30/2021 to identify if falls occurred while toileting without proper supervision. There was none identified. Current residents were	1/4/22

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

Electronically Signed | 12/31/2021

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F 689	Continued From page 1 A nursing Admission Assessment dated 9/21/21 determined the resident was not at risk for falls. However, she was reported to have a history of 1-2 falls in the past 3 months prior to admission to the facility. The baseline care plan for Resident #1 was dated 9/22/21. The Functional Status and Mobility of the resident indicated she required one person physical assist for personal hygiene, toilet use, dressing, bathing, bed mobility and transfers. Resident #1 ' s Physical Therapy (PT) plan of care dated 9/22/21 noted the following precautions for this resident: fall risk, decreased safety awareness, and low endurance requiring frequent rests. The initial PT assessment indicated her current level of mobility going from sitting to standing required substantial / maximal assistance. The resident ' s level of function for toilet mobility was, "Not attempted due to medical condition or safety concerns." Resident #1 ' s Occupational Therapy (OT) plan of care dated 9/22/21 also reported the resident required fall precautions. This assessment indicated Resident #1 was oriented x 2 (to person and time) and included a Brief Interview of Mental Status (BIMS). A BIMS score of 11 out of 15 was indicative of moderate cognitive impairment. Resident #1 ' s Comprehensive Care Plan included the following area of focus, in part: --The resident is at risk for falls related to dementia, impaired mobility, muscle weakness (Date Initiated: 9/22/21). The interventions were as follows: --Be sure the resident's call light is within reach and encourage the resident to use it for	F 689	reviewed by the Director of Nursing, the MDS nurses, Social Services department and Therapy department on 12/30/2021 using their diagnosis, falls history, current BIMS score, and current plan of care to determine if they require supervision while on the toilet. The plan of care will be revised if indicated to reflect how much assistance is needed to transfer to the toilet and if constant supervision while on the toilet is required and will also linked to the Kardex. New admissions and readmissions will be discussed as part of clinical startup with updates to their plan of care related to toileting transfer assistance need and if constant supervision is warranted. Education will be provided by the Director of Nursing or the Assistant Director of Nursing to licensed nursing staff, nursing assistants, and therapists that they need to follow the residents plan of care and Kardex as to the need for residents transfer assistance to the toilet and if the are to have constant supervision while on the toilet. This education will be completed by 01/04/2022. This education will include new hires and agency staff. The Director of Nursing or designee will do random observations of a minimum of 5 residents weekly when being toileting to validate that their plan of care is being followed. An auditing tool will be used to record the observation results. This will be ongoing for 12 weeks. The results of the audit will be discussed at QAPI for three months and at the end of the three	

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F 689	Continued From page 2 assistance as needed. The resident needs prompt response to all requests for assistance. (Date Initiated: 9/22/21); --Ensure that the resident is wearing appropriate footwear. (Date Initiated: 9/22/21); --Physical Therapy (PT) evaluate and treat as ordered or as needed. (Date Initiated: 9/22/21); --The resident needs to be evaluated for and supplied appropriate adaptive equipment or devices as needed. Re-evaluate as needed for continued appropriateness and to ensure least restrictive device or restraint. (Date Initiated: 9/22/21); --The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach. (Date Initiated: 9/22/21). The resident ' s comprehensive care plan did not indicate the level of staff assistance required for completion of her Activities of Daily Living (ADLs). A physician progress note for Resident #1 (dated 9/24/21) documented under the heading "Special Instructions": "Has pneumonia and COPD (chronic obstructive pulmonary disease) is received ABT (antibiotic) ...Receiving PT/OT ...Is Fall Risk (typed in capital letters)." Resident #1 ' s admission Minimum Data Set (MDS) assessment dated 9/26/21 indicated she had moderately impaired cognitive skills for daily decision making. Section G (Functional Status) of the MDS reported the resident required extensive assistance with two plus (2+) persons physical assist for bed mobility, transfers, dressing, toileting, and personal hygiene.	F 689	months, the QAPI committee will decide if the audits need to continue. The Director of Nursing is responsible to ensure the plan of correction is completed by 01/04/2022.	

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Resident #1 was frequently incontinent of bladder and bowel. The MDS also reported she had a history of falls prior to admission to the facility.

A review of Resident #1 ' s Care Area Assessment (CAA) worksheet for Falls dated 10/4/21 included an "Analysis of Findings." These findings read, in part: "(Resident #1) is admitted in rehab post hospitalization for Pneumonia, right lower lobe, and mechanical falls at home ...She is alert with confusion and memory loss. She requires extensive assistance with her ADLs..." A decision was made to include Falls in the resident ' s care plan. The Care Plan Considerations reported, "at risk of falls due to impaired mobility with weakness and (history) of falls will minimize risk (through) nursing assessment and intervention. Assist with bed mobility and transfers continue to participate in therapy for strengthening."

The OT Therapist Progress Notes dated 10/5/21 described her current level of self-care with toileting hygiene as, "The patient performs all toileting tasks utilizing bedside commode frame above commode with moderate assistance (26-75% assist) and 75% verbal instruction/cues." A notation also reported, "Pt (patient) continues to require assistance for all tasks due to self limiting behavior, weakness, decreased problem solving." Results of updated standardized tests conducted for Resident #1 included a BIMS score of 7 out of 15, reflecting a decline since her initial OT evaluation. A BIMS score of 7 may be indicative of severe cognitive impairment.

A Nurse Practitioner (NP) progress note dated 10/7/21 reported Resident #1 ' s lab results indicated she had a bacterial urinary tract

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infection (UTI) with dysuria (painful or difficult urination). An order was received to treat the resident with a course of antibiotics.

A review of the resident ' s PT Daily Treatment Notes included a notation dated 10/7/21. The note reported Resident #1 participated in a wheelchair to commode (and back again) transfer with minimum assist of one person. The resident ' s standing balance required minimum assist of one person with maximum cues for safety.

An Incident Report dated 10/8/21 at 10:19 PM and authored by Nurse #1 documented Resident #1 had an "unattended fall" in her bathroom. The Nursing Description reported, "Noted on floor in front of toilet calling out, red thin drainage noted from top of head. The Resident Description read, "tried to get up and got light headed and I fell over." Resident #1 was assessed. She was noted to be alert, verbal, and oriented to person with some confusion to time. The resident ' s Medical Doctor (MD) was notified of the fall and an order received to send her to the Emergency Department (ED) for evaluation of a head laceration and completion of a computerized tomography (CT) scan.

The hospital records indicated Resident #1 arrived in the ED on 10/8/21 at 11:02 PM via ambulance with a chief complaint of sustaining a fall and head laceration. The history provided by Resident #1 read: " ...Patient states she was using the toilet, got up, bent over to pick up her pants got dizzy and fell forward hitting the back of her head. Patient states that over the last few months she has had multiple episodes where she gets dizzy when bending over ..." The hospital record reported Resident #1 ' s head laceration

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was 0.8 centimeters (cm). A tissue adhesive (glue) was used to repair the laceration. A computerized tomography (CT) scan was completed. Results of the CT scan read: "No acute intracranial process. Chronic atrophy (a loss of neurons or nerve cells over a long period of time) and small vessel ischemic change (a condition where blood flow is restricted), unchanged compared to prior."

The resident was discharged from the hospital ED back to the facility on 10/9/21 at 3:50 AM.

A review of the facility ' s documents included a Resident Care Specialist (RCA) Assignment Sheet (not dated). This record indicated the "Assist needed" by Resident #1 was "limited." Limited assist was specifically indicated for Resident #1 to "Turn (Bed Mobility)" and "Transfer / Ambulation."

An interview was conducted on 12/8/21 at 1:24 PM with a Physical Therapist (PT) who had evaluated and worked with the resident while she was receiving rehab at the facility. Upon review of her notes, the PT reported Resident #1 was a fall risk due to her poor safety awareness. The PT reported she worked with Resident #1 on 10/8/21 (the date of her fall). On 10/8/21, the resident participated in walking with the PT but required a lot of cueing for safety maneuvering with supervision and contact guard assist.

A telephone interview was conducted on 12/9/21 at 12:14 PM with Nurse Aide (NA) #1. NA #1 was an Agency (temporary staff) NA who was assigned to care for Resident #1 during 2nd shift on 10/8/21 (at the time of her fall). The NA reported 10/8/21 was only the second time she

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had worked at the facility and it was the first time she had cared for Resident #1. During the interview, the NA stated she recalled Resident #1 and the events of 10/8/21 stating, "I remember it like it was yesterday." NA #1 reported the resident ' s family member was visiting the evening of 10/8/21 and was with Resident #1 the first time she took her to (and from) the toilet. The NA stated the resident had a bed pan to use but the family member wanted her to use the toilet since she was planning to go home soon. NA #1 reported "probably an hour" after the family member left, the resident told the NA she needed to go to the bathroom again. The NA stated she helped Resident #1 to the bathroom and transferred her to the toilet (with contact guard assist). She told the resident to ring the call bell when she was done. The NA reported she left the resident unattended while she was on the toilet. She stated, "I stepped out to help another resident ...gone only 30-40 seconds ...all I know I can remember she had fallen." The NA reported Resident #1 had apparently tried to get up by herself and fell. When asked if the family member was still visiting the resident when she was put on the toilet, the NA answered, "Not the last time, no."

An interview was conducted on 12/8/21 at 3:28 PM with the facility ' s second shift Nurse Supervisor (Nurse #1). This nurse was identified as having worked on 10/8/21 when Resident #1 sustained the unwitnessed fall in her bathroom. Nurse #1 reported when she was doing her rounds around 10:00 PM that evening, Resident #1 ' s family member asked her to get the NA to take her to the toilet (which she did). In the meantime, she stated the family member left without telling anybody the resident was on the

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toilet. The next time she saw the resident was when she was on the bathroom floor in front of the toilet. The nurse stated normally staff would not have left Resident #1 on the toilet without someone being with her. However, she reported the family member was initially there with the resident when the resident was assisted to the toilet. A follow-up telephone interview was conducted on 12/9/21 at 3:27 PM with Nurse #1. When asked, the nurse stated she was certain Resident #1 ' s family member was in the room when she went to get the NA for toileting assistance. The nurse stated it was "minutes" later when she went back to check on things and found the resident on the floor.

An interview was conducted on 12/8/21 at 3:11 PM with the facility ' s Director of Nursing (DON). During the interview, Resident #1 ' s fall on 10/8/21 was discussed. The DON reported she received a call from Nurse #1 the night of Resident #1 ' s fall. The DON stated she was told the resident ' s family member was at the facility and insisted the resident be put on the toilet instead of using a bed pan. The DON also reported she was told the resident ' s family member was with the resident when the NA assisted her to the toilet. She stated the NA walked out of the room because the family member was there; the resident was not unattended. However, the family member left without telling anyone. The NA went back and the resident was on the floor. A follow-up telephone interview was conducted with the DON on 12/9/21 at 1:11 PM. During the interview, the DON reported she had not talked directly with NA #1 about Resident #1 ' s fall on 10/8/21. She reiterated that an oral report describing the incident was given to her by Nurse #1. A second

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follow-up telephone interview was conducted with the DON and Administrator on 12/9/21 at 2:36 PM. At this time, the DON reported Resident #1 was able to use the call light.

A telephone interview was conducted on 12/9/21 at 1:57 PM with Resident #1 ' s family member. During the interview, the family member was asked to describe the events that occurred the evening of 10/8/21. The family member reported while she was visiting Resident #1, the resident needed to use the bathroom and NA #1 assisted her to the toilet. The family member recalled she told the NA she would watch Resident #1 while she was in the bathroom. A few minutes later, the NA came back in and assisted the resident off of the toilet and back to bed. The family member reported she specifically told the NA if she (the family member) wasn ' t there to stay with the resident while she was on the toilet, the NA would not be able to leave her unattended in the bathroom. When asked, the family member stated the resident was back in bed when she left around 9:00 PM the evening of 10/8/21. The family member reported she was not at the facility when the resident was put back on the toilet and left unattended before she fell.