

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>345312</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>07/17/2015</b>
NAME OF PROVIDER OF SUPPLIER <b>BRIAN CTR HEALTH &amp; REHAB/HENDERSONVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1870 PISGAH DRIVE HENDERSONVILLE, NC 28791</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0323  Level of harm - Actual harm  Residents Affected - Few	<p><b>Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p><b>Based on record reviews and staff interviews the facility failed to provide supervision for a resident who fell from bed and fractured his right hip for 1 of 3 sampled residents for accidents. (Resident #192).</b></p> <p>The findings included: Resident #192 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #192 was discharged from the facility to the hospital on [DATE] and did not return to the facility. A review of a discharge Minimum Data Set ((MDS) dated [DATE] indicated Resident #192 had no short term memory impairment and he was independent in cognitive skills for daily decision making. The MDS also indicated Resident #192 required extensive assistance with transfers and required supervision while walking in his room and he had a nephrostomy tube (a tube placed through the abdomen for drainage of urine) and he was occasionally incontinent of bowel.</p> <p>A review of an interim plan of care dated [DATE] indicated potential and actual falls due to a history of falls, decreased safety awareness and weakness. The goals indicated Resident #192 would be free of fall related injury through next review and interventions included in part for pressure pad alarm, call light within reach and a bed alarm.</p> <p>A review of a facility document titled Fall Risk Evaluation dated [DATE] revealed Resident #192 had a total risk score of 14 (a score of 10 or greater represented high risk for falls).</p> <p>A review of a facility document titled Fall Risk Evaluation dated [DATE] revealed a total risk score of 18 and indicated predisposing disease of weakness and a history of falls.</p> <p>A review of a facility document titled Situation, Background, Assessment and Request (SBAR) communication form and progress note dated [DATE] indicated Resident #192 had a fall on [DATE]. The section labeled Background indicated Resident #192 had a urinary tract infection, kidney failure and anemia. A section labeled Request included nurse's notes and revealed Resident #192 was lying on the floor and when asked why he was in the floor he stated he was going to the bathroom and fell . The notes indicated in part Resident #192 was able to move all extremities without any difficulty, had no complaints of pain and he was lifted back to bed and his back and buttocks were assessed after he was in bed and no redness or broken areas of skin were noted.</p> <p>A review of an incident and accident report dated [DATE] indicated the date of incident was [DATE] at 4:30 AM and the location was in the resident's room. The report indicated the resident's description of the incident when he was found lying beside his bed revealed he was going to the bathroom and fell . A section labeled equipment involved was checked as no and a section labeled resident outcome was checked as no apparent injury. A section labeled description of incident and accident indicated a primary assessment was completed when he was in bed and he was turned on his side for the nurse to do the assessment.</p> <p>A review of a physician's progress notes dated [DATE] but did not have a time documented revealed in part Resident #192 had a fall on [DATE] in the early morning. The notes indicated Resident #192 stated he was attempting to get to the bathroom and fell and thought he landed on his back but denied hitting his head. The notes further indicated Resident #192 was complaining of right hip and groin pain and he was alert and oriented to time, place and person and was lying in bed guarding his right hip. The notes revealed Resident #192 was frail and had general wasting of his body and his right lower extremity was shortened and was externally rotated (turned outward) and he complained of pain with palpation of his right femur (thigh bone). The notes further revealed x-rays were ordered and to continue neurological checks and fall precautions.</p> <p>A review of an x-ray report dated [DATE] indicated the right hip showed an acute, slightly angulated intertrochanteric (the upper part of the thigh bone) fracture and osteopenia (reduced bone mass of lesser severity than osteoporosis) was present and there were degenerative changes.</p> <p>A review of a physician's orders [REDACTED] #192 to the emergency room for acute right intertrochanteric fracture.</p> <p>A review of a Resident Transfer Form dated [DATE] with no time documented indicated to transfer Resident #192 to the hospital and the reason for transfer was right femur fracture. No time of transfer was documented.</p> <p>A review of a Nursing Daily Skilled Summary dated [DATE] at 2:00 PM revealed in part Resident #192's right hip was found to be positive for fracture by x-ray at 11:45 AM and he was sent out to the hospital for evaluation.</p> <p><b>During an interview on [DATE] at 2:53 PM with Resident #192's roommate who was cognitively intact for daily decision making he explained he remembered the night Resident #192 rolled out of bed onto the floor. He stated prior to the fall a Nurse Aide (NA) was in the room around 11:00 PM on [DATE] and provided care to Resident #192. He further stated no staff came back into the room after that until Resident #192 rolled out of bed and hit the over bed table and it bumped into his bed and he looked and saw Resident #192 on the floor. He explained he pushed the call light but nobody came to the room so he sent a text on his phone to a family member to call the nurse's station to tell them to check on Resident #192. He confirmed he sent the text message at 4:28 AM and a nurse came in the room at 4:36 AM. He explained the nurse called for assistance and another nurse and 2 Nurse Aides (NAs) came into the room and picked Resident #192 up off the floor and put him in the bed. He stated he asked Resident #192 what had happened and he said he needed to go to the bathroom and fell .</b></p> <p><b>During a phone interview on [DATE] at 3:50 PM with a family member of Resident #192 she stated Resident #192 had hip surgery after he went to the hospital and was discharged to another facility but had recently expired because he never recovered and could not walk. She further stated the roommate had reported to her that NAs had not checked on Resident #192 during the night and he had to text his family to call the nurses station because they did not answer the call light.</b></p> <p><b>During an interview on [DATE] at 10:23 AM with Certified Medication Aide #2 she explained she arrived at the facility at 3:00 AM on [DATE]. She explained at night there was 1 Nurse Aide on the hall where Resident #192 lived to provide care to residents. She stated NAs were supposed to do rounds and check on residents every 2 hours or more often as needed. She further stated she did not go into Resident #192's room on [DATE].</b></p> <p><b>During an interview on [DATE] at 10:43 AM with Nurse #4 who identified herself as a Unit Manager of the unit where Resident #129 lived explained when she arrived at the facility in the morning on [DATE] after Resident #192's fall Nurse #5 who was assigned to Resident #192's care on the night shift stated he was found on the floor in his room around 4:30 AM. She stated Nurse #5 also reported she had assessed Resident #192 and she didn't think he was injured.</b></p> <p>During an interview [DATE] at 11:16 AM with a Nurse Practitioner she explained she saw Resident #192 on [DATE] during the morning after his fall. She stated she got to the facility around 8:00 AM and the nurses told her he had fallen and she went to his room. She stated Resident #192 was alert with clear speech and he told her he was trying to go to the bathroom. She explained when she examined him he was very guarded with his right leg and it was shortened and externally rotated. She</p>		

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

TITLE

(X6) DATE

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 0323  <b>Level of harm - Actual harm</b>  <b>Residents Affected - Few</b>	<p>(continued... from page 1)</p> <p>stated Resident #192 was complaining of right hip and groin pain and she thought he had fractured his hip or leg so she ordered x-rays to be done immediately in the facility and the results showed a right hip fracture. She further stated she then wrote orders to send him to the hospital</p> <p>During an interview on [DATE] at 12:21 PM with Nurse #2 he explained he was the day shift nurse on [DATE] after Resident #192 had a fall and received report from Nurse #5. He stated Nurse #5 reported to him that Resident #192 had fallen and was found on the floor in his room around 4:30 AM. He explained she said she checked for range of motion in Resident #192's legs, his pain level and said he appeared to be alright. He stated he saw Resident #192 later that morning and he complained of pain and he gave him pain medication. He further stated he was not sure if Resident #192 was a fall risk and did not recall fall prevention interventions.</p> <p>During an interview on [DATE] at 2:22 PM with Nurse #5 who was assigned to care for Resident #192 during the night shift on [DATE], she stated she was going down the hall to take a resident a snack around 4:30 AM and then she looked in on Resident #192 and he was lying in the floor next to his bed. She stated she had not been in Resident #192's room since the beginning of her shift at 11:00 PM. She further stated she assessed Resident #192 while he was in the floor and she didn't see any obvious injury so she called for NAs to help her put him back in bed. She explained NAs were supposed to do rounds and check on resident's every 2 hours or more often as needed but no one had checked on Resident #192 after 11:00 PM that she was aware of.</p> <p>During an interview on [DATE] at 3:28 PM with the Area Staff Development Manager she explained she was the former Director of Nursing (DON) in the facility when Resident #192 fell on [DATE]. She stated when she got to the facility staff told her Resident #192 had fallen. She stated she started an investigation but did not interview Resident #192 because he was sent to the hospital. She stated she got a statement from the NA who was assigned to Resident #192 during the night shift and was told she assisted Resident #192 with care at 11:15 PM and did not go back in his room after that. She confirmed the NA no longer worked at the facility and attempts to contact her by phone were unsuccessful. She stated it was her expectation that staff should make rounds and check on residents every 2 hours or more often as needed.</p>		
F 0514  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Keep accurate, complete and organized clinical records on each resident that meet professional standards</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on record reviews and staff interviews the facility failed to document time of a resident fall and time of nurses notes on a change of condition form, time of nurse practitioner assessment, time of transfer to a hospital and failed to document severity and location of pain and effectiveness of pain medication for a resident who had a [MEDICAL CONDITION] after he fell from bed for 1 of 3 residents sampled for accidents. (Resident #192).</p> <p>The findings included:</p> <p>Resident #192 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #192 was discharged from the facility to the hospital on [DATE] and did not return to the facility. A review of a discharge Minimum Data Set ((MDS) dated [DATE] indicated Resident #192 had no short term memory impairment and he was independent in cognitive skills for daily decision making. The MDS also indicated Resident #192 required extensive assistance with transfers and required supervision while walking in his room.</p> <p>A review of a facility document titled Interdisciplinary Post Fall Review dated 02/09/15 indicated time of Resident #129's fall was 4:30 AM.</p> <p>A review of a facility document titled Situation, Background, Assessment and Request (SBAR) communication form and progress note dated 02/09/15 indicated Resident #192 had a fall on 02/09/15 but there was no documentation for time of the fall and a section of handwritten nurses notes did not have a time documented.</p> <p>A review of a Medication Administration Record indicated Resident #192 received [MEDICATION NAME] 50 milligrams (mg) by mouth for hip pain on 02/09/15 at 6:30 AM but there was no documentation of the level of pain on a scale of 0 (no pain) to 10 (worst pain) and there was no documentation of the effectiveness of the pain medication.</p> <p>A review of a Medication Administration Record dated 02/09/15 indicated Resident #129 was given [MEDICATION NAME] 4 mg by mouth for pain at 10:05 AM but there was no documentation of the location of pain and there was no documentation of the level of pain on a pain scale of 0-10.</p> <p>A review of physician's progress notes dated 02/09/15 did not include documentation of the time the Nurse Practitioner saw Resident #192.</p> <p>A review of a MAR dated 02/09/15 indicated Resident #129 received [MEDICATION NAME] 4 mg by mouth on at 12:45 PM for complaint of pain but there was no documentation of the level of pain on a scale of 0-10, there was no documentation of the location of pain and there was no documentation of the medication's effectiveness.</p> <p>A review of a Nursing Daily Skilled Summary dated 02/09/15 at 2:00 PM indicated neuro checks had been continued for post fall and right hip was found to be positive for fracture at 11:45 AM and Resident #192 had been sent to the hospital for hip evaluation.</p> <p>A review of a facility document titled Resident Transfer Form dated 02/09/15 did not include time of transfer to the hospital.</p> <p>During an interview on 07/17/15 at 10:43 AM with Nurse #4 who identified herself as a Unit Manager of the unit where Resident #129 lived stated after she reviewed the documentation in Resident #129's medical record there should have been documentation of the time of Resident 129's fall and time nurses notes were documented on the on the SBAR form and the time of transfer to the hospital on the resident transfer form. She explained nursing staff had documented neurological checks every 30 minutes on a Neurological Record as their assessment of Resident #129 but it did not include information about Resident's severity of pain. Nurse #4 confirmed the severity of Resident #129's pain was not documented but should have included the severity of his pain according to the pain scale from 0-10. She further stated Resident #129 was alert and oriented and would have been able to state what his pain level was. She also stated she expected to see documentation of the location of pain and the effectiveness of pain medication.</p> <p>During an interview on 07/17/15 at 11:16 AM the Nurse Practitioner stated she forgot to document the time she saw Resident #129 on 02/09/15. She stated she was working on trying to remember to put the time with the date when she documented her notes.</p> <p>During an interview on 07/17/15 at 12:21 PM with Nurse #2 he explained he was the day shift nurse after Resident #192 had a fall on 02/09/15 and gave Resident #129 pain medication. He verified he gave Resident #129 pain medication at 10:05 AM because he complained of hip pain and gave pain medication again at 12:45 PM just before Resident #129 left the facility to go to the hospital because of continued hip pain. He explained Resident #129 was not in severe pain but described his pain as moderate. He further explained he was supposed to document severity of pain with a pain scale from 0-10 but he did not document Resident #129's severity of pain because there was no place to write it on the MAR and he had forgotten to document location of pain or pain medication effectiveness.</p> <p>During an interview on 07/17/15 at 2:22 PM with Nurse #5 who was assigned to care for Resident #192 during the night shift she confirmed she filled out the SBAR form and the notes on the form were her nurse 's notes. She stated she assessed Resident #129 while he was on the floor and again after they put him to bed. She further stated that Resident #129 did not complain of pain when she found him in the floor but later he complained of pain and she gave him pain medication. She stated she did not recall the severity of his pain but stated he was not in severe pain and she had forgotten to document the level of his pain according to the pain scale and effectiveness of the pain medication. She further stated she did not know why she did not put the time of Resident #192's fall or the time she documented her nurse's notes on the SBAR form but she must have forgotten it.</p> <p>During an interview on 07/17/15 at 3:28 PM with the Area Staff Development Manager explained she was former Director of Nursing (DON) in the facility when Resident #192 fell on [DATE]. She stated it was her expectation that the time of Resident #129's fall and time nurses notes should have been documented on the SBAR form and the time of transfer to the hospital should have been documented on the transfer form. She stated she also expected to see documentation of the severity of the pain, location of pain and if pain medication was effective on the MAR or in the nurses notes.</p>		

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