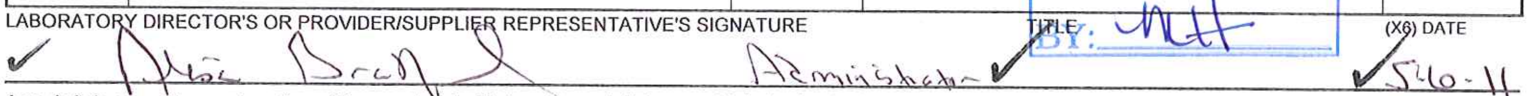
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING ______ B. WING ______	C 04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(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 000	INITIAL COMMENTS No deficiencies cited as a result of Complaint Investigation completed 04/14/2011. Event ID # H6UY11.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to clarify and transcribe physician's orders to reflect the correct route and/or instructions for administration of medications for four/(4) of eleven (11) sampled residents. (Resident #89, 108, 132, 204). The findings are: 1. Resident # 89 was admitted to the facility 05/17/2006 with diagnoses including Convulsions and Anxiety. Review of the medical record revealed a physician's order dated 09/15/2010 for Clonazepam (for anxiety) 0.25 milligram (mg) to be administered at 09:00 AM and 7:00 PM. On the monthly Physicians Order Sheets (POS) and Medication Administration Records (MAR) for October, November, and December 2010 and for January, February, March, and April 2011 the 09/15/2010 physician's order was transcribed as "Clonazepam give 0.25 milligram (mg) total dosage Nasal BID (twice daily)." Interview, 04/13/2011 at 10:20 AM, with the facility Pharmacy Consultant revealed original physician's orders as well as monthly POS and	F 281	F281 1. The alleged deficient practice identifying 4 residents without correct route and/or instructions for administration of medications on physician's orders was corrected as follows: Resident #89 -, The Assistant Director of Nursing clarified order of Clonazepam to include route of administration " PO". Resident #108 - The Assistant Director of Nursing clarified order of Miralax powder to include route of administration " PO". Resident #132 – The Assistant Director of Nursing clarified orders for Miralax, Oxycodone, MS Contin, Resiperdone, and Ambien to include route of administration "PO". Resident #204 – The Assistant Director of Nursing clarified orders for Hyzaar, NuIron, and Macrobid to include route of administration "PO". *Preparation and/or execution of the 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 provision of the Federal and State law.* RECEIVED MAY 09 2011 BY:	5-12-11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5-10-11

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 281	Continued From page 1 MARs should include specific directions and routes of medication administration. The Pharmacist stated Licensed Nursing (LN) staff should contact the physician for clarification when administration routes and/or directions were incorrect or omitted from the physician's order. The Pharmacist stated LN staff refer to the monthly MAR during medication administration thus accurate directions were required to ensure that residents' medications were administered safely and as intended by the physician. The Pharmacists was not available for follow up interview after the discovery of the transcription error regarding administration of Resident #89's Clonazepam via Nasal route. On 04/13/2011 at 4:50 PM, after reviewing the March 2011 MAR, the Director of Nursing (DON) confirmed Resident #89's 09/15/2010 physician's order for Clonazepam was incorrectly transcribed. The DON stated the order should have been transcribed to reflect administration of the medication by mouth. On 04/14/2011 at 9:30 AM an interview was completed with the LN assigned to Resident #89. During the interview LN #5 stated Resident #89 was was receiving the Clonazepam, ordered 09/15/2010, via mouth. LN #5 stated prior to the beginning of each month LN staff were responsible for checking the monthly POS and MAR against the current POS and MAR and physician's order and for signing that the orders were accurate and complete. The interview further revealed LN #7 was responsible for reviewing and verifying the October 2010 POS and MAR for Resident #89. On 04/14/2011 at 1:25 PM a follow up interview	F 281	F281 continued 2. Facility residents have the potential to be affected by the same alleged deficient practice. The Assistant Director of Nursing audited all residents on Rehab. Unit to identify additional residents' orders without route of administration. Audit was completed on 4/15/2011 which revealed an additional 6 orders lacking route with clarifications or orders written stating the correct route. An audit of remainder of the building to be completed by May 6, 2011 with any discrepancies found to have clarification orders written to include route of administration. 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: Unit Manager will review physician's telephone orders daily Monday thru Friday for correct transcription of orders to include route of administration of medication ordered. Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit all new admissions and 10% of the monthly Medication Administration Records to review for correct transcription of orders with any discrepancies clarified. The Staff Development Coordinator in-serviced Licensed Nurses in regard to accurate transcription of medications to include name of medication, route to be given, dosage of medication, times of administration, and diagnosis and the Federal/State regulations pertaining to this tag by 05/06/11. *Preparation and/or execution of the 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 provision of the Federal and State law.*	

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F 281	Continued From page 2 was completed with the DON. During the interview the DON reported that each month residents' monthly POS and MARs were generated from information entered into the computer by the Unit Assistant and/or Central Supply Clerk. The DON stated Resident #89's Clonazepam order of 09/15/2010 was entered into the computer incorrectly and LN #7 assigned to review the October 2010 POS and MAR failed to identify that the medication was to be administered by mouth rather than nasally. Since the error was not caught, corrected, and forwarded to the Unit Assistant/Central Supply Clerk to be changed in the computer the error continued to be reflected each month on the POS and MAR. The DON reported, during subsequent reviews of the each monthly POS and MAR, LN staff should have identified and corrected the transcription error. LN #7, responsible for reviewing, verifying, and signing that Resident #89's October 2010 POS and MARs were accurate and complete, was not available for interview during the survey. 2. Resident #108 was admitted to the facility 02/15/2011 with diagnoses including Constipation. Review of physician's order in the medical record and the March 2011 Physician's Order Sheet (POS) revealed an admission physician's order, dated 02/15/2011, for Miralax Powder (laxative) 17 grams to be administered by mouth daily. On the Medication Administration Record (MAR) for March 2011 the physician's order was transcribed to read "Miralax 17 grams q (every) hs (hour of sleep). The MAR revealed no route of administration for the Miralax. Further review of the 02/15/2011 original physician's order and the March 2011 "Physicians Order	F 281	F 281 continued 4. The Director of Nursing will review audits to identify patterns or trends. All data results will be presented to the QA & A Committee weekly for four weeks and then monthly for three months. The QA& A Committee will evaluate the effectiveness of the plan based on the outcomes identified and will adjust plan as needed. Corrective action will be completed by May 12, 2011. *Preparation and/or execution of the 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 the Federal and State law.*	

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F 281	Continued From page 3 Sheet" and MAR revealed no instructions for mixing the medication with fluids. The Miralax manufacturer label included directions to dissolve the powder into four (4) to eight (8) ounces of fluids prior to administration. Interview, 04/13/2011 at 10:20 AM, with the facility Pharmacy Consultant revealed the original physician's order as well as monthly POS and MARs should include specific directions and a route for medication administration. The Pharmacist stated Licensed Nursing (LN) staff should contact the physician for clarification when route and/or directions for administration were omitted from the physician's order. The Pharmacist stated LN staff refer to the MAR during medication administration thus accurate and complete directions were required to ensure that residents' medications were administered safely and as intended by the physician. On 04/14/2011 at 1:10 PM an interview was completed with the LN responsible for transcribing Resident #108's 02/15/2011 physician's orders and for verifying the March 2011 POS and MAR. During the interview LN #4 confirmed the Miralax order did not include instructions or a route for administration. LN #4 stated the Miralax should be mixed with eight (8) ounces of fluids prior to administration. LN #4 stated she did not obtain clarification or additional instructions from the physician regarding Resident #108's 02/15/2011 Miralax order. On 04/14/2011 at 1:25 PM an interview was completed with the Director of Nursing (DON). During the interview the DON the DON reviewed the POS and MAR and confirmed Resident #108's Miralax order should have included a route	F 281		

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F 281	Continued From page 4	F 281		

and directions for administration. The DON reported that the Unit Assistant and/or Central Supply Clerk were responsible for transcribing residents' admission physician's orders to the resident's MAR. LN staff then compared the MAR to the original order to ensure the orders were complete and transcribed correctly. The DON further revealed within twenty four (24) to thirty six (36) hours of admission all physician's orders and MARs were reviewed by the Unit Nurse Manager for completeness and accuracy. The DON stated the incomplete physician's order should have been identified by LN #4 and/or Unit Manager and the physician should have been contacted for clarification and correction of the incomplete medication order for Resident #108.

3. Resident #132 was admitted to the facility 04/04/2011 with diagnoses including Femur Fracture, Osteoporosis, Depression, and Dementia. Review of Resident #132's medical record and March 2011 Medication Administration Record (MAR) revealed 04/04/2011 admission physician's orders as follows:

Miralax 17 gram in eight (8) ounces water BID (twice daily)
Oxycodone/APAP 5/325 milligram (mg) every four (4) hours PRN (as needed for pain)
MS (Morphine Sulfate) Contin 15 mg two (2) tablets BID
Risperidone 0.5 mg Q HS (at bed time)
Ambien 5 mg Q HS (at bed time) as needed for insomnia

Further review of the 04/04/2011 physician's admission orders and the March 2011 MAR revealed no route of administration for the above medications.

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F 281	Continued From page 5 Interview, 04/13/2011 at 10:20 AM, with the facility Pharmacy Consultant revealed original physician's orders as well as monthly POS and MARs should include specific directions and routes for medication administration. The Pharmacist stated Licensed Nursing (LN) staff should contact the physician for clarification when routes and/or directions for administration were omitted from the physician's order. The Pharmacist stated LN staff refer to the monthly MAR during medication administration thus accurate and complete directions were required to ensure that residents' medications were administered safely and as intended by the physician. On 04/14/2011 at 9:20 AM an interview was completed with the LN assigned to Resident #132. During the interview LN #6 reviewed Resident #132's March 2011 MAR and 04/04/2011 physician's orders and confirmed no specific route of administration was included in the orders for Miralax, Oxycodone/APAP, MS Contin, Risperidone, and Ambien. LN #6 stated Resident #132 was receiving the medications by mouth. LN #6 stated LN staff were responsible for reviewing, verifying, and signing that the physician's admission orders and MAR were accurate and complete. The interview further revealed LN #9 signed Resident #132's admission physician's orders and March 2011 MAR indicating that the orders were accurate and complete. On 04/14/2011 at 1:25 PM an interview was completed with the Director of Nursing (DON). During the interview the DON reviewed Resident #132's 04/04/2011 admission physician's orders	F 281		

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F 281	Continued From page 6	F 281		

and March 2011 MAR and confirmed that the route of administration was omitted from the Miralax, Oxycodone/APAP, MS Contin, Risperidone, and Ambien orders. The DON reported that the Unit Assistant and/or Central Supply Clerk were responsible for transcribing residents' admission physician's orders to the resident's MAR. LN staff then compared the MAR to the original order to ensure the orders were complete and accurately transcribed. The DON further revealed within twenty four (24) to thirty six (36) hours of admission all physician's orders and MARs were reviewed by the Unit Nurse Manager for completeness and accuracy. The DON stated the incomplete physician's order should have been identified by LN #9 and/or Unit Manager and the physician should have been contacted for clarification and correction of the incomplete medication order for Resident #132.

LN #9, responsible for reviewing, verifying, and signing that Resident #132's admission orders and March 2011 MAR were accurate and complete, was not available for interview.

4. Resident #204 was admitted to the facility 04/07/2011 with diagnoses including Hypertension, Cardiomegaly, and Urinary Tract Infection. Review of Resident #204's medical record and March 2011 Medication Administration Record (MAR) revealed 04/07/2011 admission physician's orders as follows:

Hyzaar 100/25 one (1) Q D (once daily)
Nulron 150 milligram (mg) BID (twice daily)
Macrobid 100 mg BID for ten (10) days

Further review of the 04/07/2011 physician's admission orders and the March 2011 MAR

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F 281	Continued From page 7 revealed no route of administration for the above medications. Interview, 04/13/2011 at 10:20 AM, with the facility Pharmacy Consultant revealed original physician's orders as well as monthly POS and MARs should include specific directions and routes for medication administration. The Pharmacist stated Licensed Nursing (LN) staff should contact the physician for clarification when routes and/or directions for administration were omitted from the physician's order. The Pharmacist stated LN staff refer to the monthly MAR during medication administration thus accurate and complete directions were required to ensure that residents' medications were administered safely and as intended by the physician. On 04/13/2011 at 4:25 PM an interview was completed with the LN assigned to Resident #204. During the interview LN #8 reviewed Resident #204's March 2011 MAR and 04/07/2011 physician's orders and confirmed no specific route of administration was included in the orders for Hyzaar, Nulron, and Macrobid. LN #8 stated Resident #204 was receiving the ordered medications by mouth. LN #8 stated LN staff were responsible for reviewing, verifying, and signing that the physician's admission orders and MAR were accurate and complete. The interview further revealed LN #10 signed Resident #204's admission physician's orders and March 2011 MAR indicating that the orders were accurate and complete. On 04/14/2011 at 1:25 PM an interview was completed with the Director of Nursing (DON). During the interview the DON reviewed Resident	F 281		

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F 281	Continued From page 8 #204's 04/07/2011 admission physician's orders and March 2011 MAR and confirmed that the route of administration was omitted from the Hyzaar, Nulron, and Macrobid medication orders. The DON reported that the Unit Assistant and/or Central Supply Clerk were responsible for transcribing residents' admission physician's orders to the resident's MAR. LN staff then compared the MAR to the original order to ensure the orders were complete and accurately transcribed. The DON further revealed within twenty four (24) to thirty six (36) hours of admission all physician's orders and MARs were reviewed by the Unit Nurse Manager for accuracy and completeness. The DON stated the incomplete physician's order should have been identified by LN #10 and/or Unit Manager and the physician should have been contacted for clarification and correction of the incomplete medication order for Resident #204. LN #10, responsible for reviewing, verifying, and signing that Resident #204's admission orders and March 2011 MAR were accurate and complete, was not available for interview.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide nail care	F 312	F 312 1. The alleged deficient practice identifying one resident the facility failed to provide nail care. Resident # 129 was corrected as follows: Resident Care Specialist cleaned and trimmed resident #129 nails on April 14, 2011. *Preparation and/or execution of the 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 the Federal and State law.*	5-12-11

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F 312	Continued From page 9 for 1 of 3 sampled residents dependent on staff for ADL care. (Resident # 129). The findings are: Resident #129 was admitted to facility 03/13/09 with diagnoses which included weakness, CVA with left hemiplegia and dementia. Review of the quarterly MDS(Minimum Data Set) dated 03/11/11 assessed the resident as having memory problems and needing extensive assistance in all activities of daily living (ADL) with limited assistance with eating. Review of the resident's ADL (activities of daily living) care plan dated 01/07/11 revealed interventions to provide extensive assist of two staff for all ADL, anticipate needs due to poor cognition, encourage resident to participate in all ADL and praise accomplishments. Review of shower schedule revealed resident was scheduled for showers on Mondays and Fridays. Observations on 04/11/11 at 9:14 a.m. revealed resident #129 sitting in a wheel chair in her room. The resident's fingernails had chipped nail polish with a dark brown debris underneath nails. Observations on 04/12/11 at 8:30 a.m., revealed Resident #129 in the dining room eating breakfast. The resident's fingernails had chipped nail polish with a dark brown debris underneath nails. The resident was feeding herself, had food spillage on her clothes and hands but denied needing help.	F 312	F 312 continued 2. Facility residents have the potential to be affected by the same alleged deficient practice. Facility residents' fingernails were observed and groomed by Resident Care Specialists on 4/14/2011. 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: Department Managers will monitor nail care weekly during routine rounds with care provided as needed. The Staff Development Coordinator will in-service Resident Care Specialists regarding services necessary to maintain appropriate nail care and the Federal/State regulations pertaining to this tag by 05/06/11. 4. The Director of Nursing along with the Management Team will review weekly for patterns and trends and will be reported to the Quality Assessment and Assurance Committee weekly for four weeks and then monthly for three months. . The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on the outcomes identified and will adjust plan as needed. Corrective action will be completed by May 12, 2011. *Preparation and/or execution of the 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 provision of the Federal and State law.*	

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F 312	Continued From page 10 Observations on 04/13/11 at 8:15 a.m., revealed Resident #129 in the dining room eating breakfast. The resident's fingernails had chipped nail polish with a dark brown debris underneath nails. The resident was feeding self and staff was observed encouraging resident to eat. Observations on 04/13/11 at 12:30 p.m., revealed resident #129 in the dining room eating her food and bread with her hands. The resident's fingernails had chipped nail polish with a dark brown debris underneath nails. Interview with Nurse Aide (NA) #1 on 04/13/11 at 2:10 p.m., revealed Resident #129 received showers on Mondays and Fridays. NA #1 stated on shower days the resident's hair was washed and nail care was done. NA #1 confirmed that the resident had a shower on Monday morning (4/11/11) and that nail care had been performed at that time. During an observation of Resident #129 on 04/13/11 at 2:15 p.m., NA #1 stated, "Her nails are dirty". NA #1 stated all residents should be groomed and have their hands and face washed prior to entering the DR. During an interview on 04/13/11 at 2:45 p.m., Licensed Nurse #1 stated the NA should clean a resident's hands/nails prior to bringing them into the dining room. During and interview on 04/13/11 at 4:45 p.m., the Director of Nursing stated it was her expectation that each resident should have their hands/nails cleaned before being brought into the dining room for meals and this one must have "just fell through the cracks".	F 312		

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(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	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interview, the facility failed to implement measures to protect the skin integrity and secure siderails for one (1) of four (4) sampled residents. (Resident #63). The findings are: 1. Resident #63 was admitted to the facility on 12/31/09. Diagnoses included difficulty in walking, peripheral neuropathy, lower back pressure ulcer, deep vein thrombosis, cardiomyopathy, spinal stenosis, muscle weakness, and congestive heart failure. The annual Minimum Data Set (MDS) dated 12/16/10 coded Resident #63 with moderately impaired cognition, feeling tired or having little energy, trouble concentrating, requiring extensive assistance for bed mobility, walking in the room, dressing, toilet use and personal hygiene. She was coded as requiring limited assistance with transfers and being able to stabilize balance with human assistance. She was coded also as taking an anticoagulant (blood thinner).	F 323	F323-D 1. The alleged deficient practice identifying one resident who did not have measures put into place to protect the skin integrity and secure side rails was corrected as follows: Resident #63 – The License Nurse obtained a clarification order for resident #63 to include long sleeve shirts on bilateral upper extremities to protect arms. The Licensed Practice Nurse for resident #63 padded the complete side rails and wheel chair arms on 4/13/2011. Maintenance tightened the bed rails of resident #63 on 4/14/2011 and evaluated all beds in the facility of that type on 4/14/2011 with no further loose bed rails identified. 2. Facility residents have the potential to be affected by the same alleged deficient practice. The Skin Care Action Team committee will review residents with a history of skin tears and bruising for the past 3 months with interventions added as identified by Skin Care Action Team Committee led by the ADON. Maintenance will evaluate all bed rails in the facility by 5/12/2011 and tighten side rails as needed. 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: *Preparation and/or execution of the 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 the Federal and State law.*	5-12-11

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	345270	A. BUILDING ____ B. WING ____	C 04/14/2011

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F 323	Continued From page 12 The quarterly MDS dated 3/15/11 coded her with long and short term memory impairment, severely impaired decision making skills, feeling down, having trouble sleeping too much, having a poor appetite, moving and or speaking slowly, and requiring extensive assistance with most activities of daily living skills. A current care plan was developed 3/20/11 and last updated 4/3/11 which addressed the problem of actual skin impairment related to thin, fragile skin. Goals included that skin tears would heal without complications and she would be free of further skin impairment related to risk factors. Interventions included observing skin weekly and document findings, observe for safety needs with transfer, gerisleeves as indicated, wound care as ordered and keep fingernails trimmed. Additions to this care plan indicated problems as follows: 3/20/11 large hematoma on left elbow sustained when resident fell; 3/24/11 bruising right upper extremity sustained from fall on 3/20/11 and a 2cm skin tear right upper extremity and 4cm skin tear left upper extremity sustained from scratching her arm; 4/3/11 3cm by 1 cm skin tear to top of left hand, approximated with steri strips. Review of the documentation on the weekly skin checks and non-pressure skin condition report revealed: 1/6/11, 1/13/11, 1/27/11 bruises randomly over body; 1/20/11 multiple bruises on body; 2/10/11, 2/10/11, 2/17/11 yes bruises - no specifics; 2/24/11 no problems; 3/10/11 bruises randomly over body; 3/17/11, 3/24/11 no problems;	F 323	F 323 continued The Director of Nursing, Assistant Director of Nursing, or Unit Manager will monitor for compliance of safety intervention compliance regarding need of padding side rails and wheel chair arms as well as monitoring for loose side rails during weekly rounds. Skin Care Action Team Committee will review residents at risk and assess appropriate intervention on a monthly basis with physicians orders obtained as necessary. Maintenance will monitor bed rails during routine weekly rounds and repair as needed. 4. The Director of Nursing will review the data obtained for patterns and trends. All data results will be presented to the QA & A Committee weekly for four week and then monthly for three months. The QA & A Committee will evaluate the effectiveness of the plan based on the outcomes identified and will adjust plan as needed. Corrective action will be completed by May 12, 2011. *Preparation and/or execution of the 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 the Federal and State law.*	

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3/26/11 left upper extremity skin tear 4 cm and right upper extremity skin tear 2cm;
3/31/11 bruises randomly over body and skin tears right upper extremity 2cm and left upper extremity 4 cm;
4/3/11 one inch skin tear on left lower leg below knee;
4/3/11 3cm x 1 cm skin tear on top of left hand;
4/7/11 skin tears - no specifics.

The Nurse aide assignment sheet used for reference of resident #63's individual care reflected gerisleeves were to be used.

Review of incident reports with the Assistant Director of Nursing (ADON) on 4/13/11 at 2:04 PM revealed the following:
*On 3/26/11 at 8 AM found bruising on right upper extremity 2cm and left upper extremity 4 cm when nurse aides went to get her out of bed with skin tears inside the bruising. She said she had been scratching and she started to bleed. The report did not address any use of gerisleeves. The ADON stated that interdisciplinary meetings were held every morning and the team looked back weekly to follow up on incidents. The ADON stated the resident sometimes will not wear gerisleeves but she could not be sure if they were on.
*On 4/3/11 at 8:30 AM 3cm x 1 cm skin tear top of left hand resident stated "I hit my hand over the bed rail" did first aid of steristrips and care plan interventions. The ADON stated there are no notes kept from morning meetings or the interdisciplinary reviews of incidents. She stated that in morning meetings staff have not discussed padding any equipment to prevent recurrences of skin tearing or bruising.

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F 323	Continued From page 14 On 04/11/11 at 03:27 PM Resident #63 was observed with multiple steristrips up her left hand, forearm and elbow, and multiple bruises on both arms and legs. She was wearing short sleeves. During staff interview on 4/11/11 at 3:27 PM, Licensed Nurse (LN) #3 stated Resident #63 had multiple bruises and skin tears on her arms and at times she hits her arms on the siderails. Resident #63 was observed on 4/12/11 at 3:22 PM laying on the bed. She was wearing a short sleeved top, without gerisleeves revealing multiple bruises up both arms. Steristrips were observed on the top of her left hand, steristrips were also observed in several places on her left arm, right arm and on her left shin. She stated she got skin tears and bruising in various ways but would or could not explain further. On 4/12/11 at 4:28 PM, Resident #63 came back to her room with family. She was wearing a long sleeved shirt over a short sleeve shirt. No gerisleeves were on and the long sleeve shirt was loose, not buttoned at the cuffs and pushed up to her elbows once back in bed, exposing her bare bruised arms. On 4/12/11 at 4:31 PM the family was interviewed. The family revealed that Resident #63 always had fragile skin which had gotten worse over the past several months. On 4/13/11 AT 9:40 AM Resident #63 was observed wearing a long sleeve blouse that was not buttoned at the wrists and slid up to expose her forearms. She was not wearing gerisleeves. There was no part of the wheelchair which was padded. On 4/13/11 at 9:57 AM NAs #2 and 3 assisted the resident back to bed. NA # 2 got	F 323		

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gerisleeves to place on her. NA #2 stated at this time that Resident #63 was gotten up by third shift who should have applied gerisleeves. NA #2 further stated that she should have noticed the missing gerisleeves before this moment.

On 4/13/11 at 11:57 AM, interview with LN #3 revealed that sometimes Resident #63 will remove the gerisleeves. She further stated that she hits the siderails with her arms at times resulting in skin tears and often has no idea how the skin tears occurred. LN #3 stated the resident has told the nurse she received skin tears from the siderail. She further stated that she was not aware if siderails have ever been padded.

On 4/13/11 at 12:11 PM NA #3 stated since she has been caring for the resident, approximately two years, there has been no padding on the siderails or wheelchair.

On 4/13/11 at 12:16 PM LN #2 stated she has been looking at Resident #63's ongoing skin issues to see what could be of help to the resident. Per LN #2, the resident does not like to wear the gerisleeves. LN #2 further stated that she thought about padding the siderails but felt the resident may feel too closed in while in bed.

4/13/11 at 2:27 PM Resident #63 was in bed on her right side holding onto the right siderail. Both siderails had blue foam taped around the front side of the bed rail (where the siderail meets the mattress to the top curve of the siderail). The siderail was not padded at the front corner of the siderail or across the top rail of the siderail or around the middle rung of the siderail.

On 4/14/11 at 9:45 AM LN #2 stated she padded

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F 323	Continued From page 16 the siderails at the front and not the top or middle based on Resident #63 telling her she hit her hand on the front of the siderail. 2. Resident #63 was admitted to the facility on 12/31/09. Diagnoses included difficulty in walking, peripheral neuropathy, lower back pressure ulcer, deep vein thrombosis, cardiomyopathy, spinal stenosis, muscle weakness, and congestive heart failure. The annual Minimum Data Set (MDS) dated 12/16/10 coded Resident #63 with moderately impaired cognition, feeling tired or having little energy, trouble concentrating, requiring extensive assistance for bed mobility, walking in the room, dressing, toilet use and personal hygiene. She was coded as requiring limited assistance with transfers and being able to stabilize balance with human assistance. The quarterly MDS dated 3/15/11 coded her with long and short term memory impairment, severely impaired decision making skills, feeling down, having trouble sleeping too much, having a poor appetite, moving and or speaking slowly, and requiring extensive assistance with most activities of daily living skills. A current care plan was developed 3/20/11 and last updated 4/3/11 which addressed the problem of actual skin impairment related to thin, fragile skin. Interventions included to observe for safety needs with transfer. The top half siderails on Resident #63's bed were were observed very loose and wobbly while she was in bed on 4/11/11 at 3:28 PM; and 4/12/11 at 3:22 PM.	F 323		

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F 323	Continued From page 17 On 4/13/11 at 8:39 AM the siderails were very loose. On 4/13/11 at 9:49 AM NA # 3 stated Resident #63 used siderails to get into bed on one side. She further stated that the resident sometimes turns herself using the siderails. On 4/13/11 at 10:02 AM, LN #2 stated that sometimes Resident #63 will use siderails to assist staff in turning. On 4/13/11 at 2:27 PM Resident #63 was in bed on her right side holding onto the right siderail. Both bed rails remained loose. On 4/13/11 at 9:22 AM the siderails remained very loose. At 9:49 AM NA # 3 stated Resident #63 sometimes used the siderail on one side to get into bed. She further stated that the resident sometimes turns herself using the siderails. On 4/13/11 at 10:02 AM, LN #2 stated that sometimes Resident #63 will use siderails to assist staff in turning. On 4/14/11 at 9:22 AM, NA #2 stated she had not noticed how loose the siderails were, saying she never paid attention. Once shown to her, NA #2 stated the siderails were very loose. On 4/14/11 at 9:45 AM LN #2 stated that the siderails were loose but she did not notice yesterday when she padded them. She stated she guessed she never paid much attention to them. On 4/14/11 at 9:28 AM, the Director of Nursing (DON) observed the siderails and agreed the siderails were too loose and needed to be tightened. On 4/14/11 at 9:48 AM, Maintenance staff #1 came to tighten the siderails . He stated that he only checked or tightened siderails when he he told of the need. The left siderail was much looser and moved 3 plus inches when wiggled before	F 323		

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F 323	Continued From page 18 tightening. On 4/14/11 at 10:00 AM the DON stated she has no method to check siderails for tightness and would have to check with maintenance to see if he checked siderail tightness routinely. On 4/14/11 at 10:05 AM the Administrator stated that they are in process to get all new beds, 3 at a time which would have tighter siderails.	F 323		