PRINTED: 08/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			RVEY ED
	345411 B. Wif		<u>ه</u>		07/28/2011		
NAME OF PROVIDER OR SUPPLIER BRIAN GENTER HEALTH AND REHAB/WAYNESVILLE				5	EEY AODRESS, CITY, STATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NG 28786	1 0112	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		LDBE	(X5) COMPLETION DAYE
F 281 SS≂D	483.20(k)(3)(i) SERV PROFESSIONAL ST	ICES PROVIDED MEET ANDARDS	F	281		r.o	
		d or arranged by the facility nal standards of quality.			F-281	ë	
	by: Based on staff interviacility failed to follow to clarify a physician (10) sampled resident (10) sampled r	mitted on 7/3/08 with ded congestive heart failure, eation and osteoporosis most recent Minimum Data fr11 specified the resident ired cognition. Thy physician orders for 7/11 twas to receive Lasix 20mg overy other day, hold if re less than 100. They Medication ds (MARs) dated 07/11 received 20 milligrams of There were no essure readings on the of the resident's medical esident had her blood			Corrective action has be accomplished for the alle deficient practice in regar Resident #74 by contacts resident's physician and obtaining a clarification. As the facility recognize alleged deficient practice potential to affected other residents, the facility has implemented additional to ensure that the alleged deficient practice does not reoccur. To include man re-education for nursing ensure continued complite These system changes in Medical Records and Un Coordinator auditing phyorders daily for complete clarity. Additionally, all orders are to be highlighthe Unit Coordinator and Records in orange to alemans to the change. Additionally and correction does not constitute admission of agreement by the provider of the truth of the constitute of the constitute of the truth of the constitute of the constitute of the constitute of the constitute of the cons	eged ards to . ing this order. ss this e has the er s measures l ot adatory staff to ance. aclude ait ysician's eness and new ted by l Medical ert the litionally, of	8/25/20
		s order dated 10/4/10 Resident #74's Lasix to	e		alleged or conclusions set forth in the state deficiencies. The plan of correction is prej and/or executed solely because it is requir provisions of federal and state law."	pared	gt .
ABORAYORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ē		ADMinistrator	8,	19 DOTE

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.

FORM CMS-2507(02-99) Previous Versions Obsciete

Event ID: FNU011

Facility ID: 923009

If continuation sheet Page 1 of 15



PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **516 WALL STREET** BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 1 F 281 20mg by mouth every other day. all new orders will be brought daily to the Morning Meeting by On 07/26/11 at 2:35 p.m. licensed nurse (LN) #2, Medical Records for additional assigned to care for Resident #74, was review and corrective actions. interviewed and stated she wasn't aware of the order to check Resident #74's blood pressure The monitoring of this new prior to administering the Lasix. She reviewed system change will continue for the physician's order sheet and MAR and six months, and may be extended, confirmed the order specified the Lasix was to be if required. held if the resident's systolic blood pressure was The DON or her designee will less than 100. She added that she routinely gave review data obtained for patterns the resident her Lasix and did not check the and trends. All data results will resident's blood pressure prior to giving the lasix. be presented to the QA&A LN #2 reviewed the medical record and Committee monthly for a period confirmed blood pressure readings were not of 6 months. The QA&A documented in the medical record as having Committee will evaluate the been taken prior to the medication being given. effectiveness of the plan based on the outcomes identified and On 07/27/11 at 11:05 a.m. the South Wing Unit adjust the plan as needed. Manager was interviewed and confirmed that 8/25/2019 blood pressure readings should have been taken and documented on the MAR or in vitals section prior to administering Resident #74's Lasix medication. On 07/28/11 at 9:30 a.m. the Director of Nursing (DON) was interviewed and stated she would expect the licensed nurses to follow physician's orders as written or to call the physician to clarify an order if they had questions. She offered no explanation why the resident's Lasix order was not followed as written.

b. Resident #74's medical record was reviewed

and revealed an original physician's order dated

Lasix to 20mg by mouth every other day.

10/4/10 that specified to decrease Resident #74's

"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 and/or executed solely because it is required by the

provisions of federal and state law."

PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYATE, ZIP CODE **516 WALL STREET** BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE YAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 281 Continued From page 2 F 281 Further review of the medical record revealed the 07/11 monthly Medication Administration Record (MARs) specified the resident received Lasix 20mg (milligrams) by mouth every other day, hold if systolic blood pressure less than 100. On 07/26/11 at 2:35 p.m. licensed nurse (LN) #2, assigned to care for Resident #74, was interviewed and stated she wasn't aware of the order to check Resident #74's blood pressure prior to administering the Lasix. She reviewed the physician's order sheet and MAR and confirmed the order specified the Lasix was to be held if the resident's systolic blood pressure was less than 100. She stated she should have clarified the order by contacting the physician. On 07/27/11 at 3:30 p.m. the medical records director was interviewed and stated that the 10/04/10 physician's orderwas to decrease Resident #74's Lasix. She stated the blood pressure parameters (hold if systolic less than 100) were not to be continued. She specified the end of month physician's orders are reconciled for accuracy and added that the order had been overlooked for the past nine (9) months. On 07/28/11 at 9:30 a.m. the Director of Nursing (DON) was interviewed and stated she would expect the licensed nurses to follow physician's orders as written or to call the physician to clarify an order if they had questions. She offered no explanation why the resident's Lasix order was not clarified. F 309 483.25 PROVIDE CARE/SERVICES FOR F 309

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HIGHEST WELL BEING

J. 74--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	UTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE	
		345411	11 B. WING		07/3	8/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				STREET ADDRESS, CITY, STATE, ZIP CO 616 WALL STREET WAYNESVILLE, NC 28788		.0.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REPERENCED TO Y DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DAYE
F 309	provide the necessary or maintain the higher mental, and psychoso accordance with the cand plan of care. This REQUIREMENT by: Based on staff interviacility failed to mand patterns for adequal patterns for three(3) or residents (Resident of the facility's "Bowel or residents or three (Bowel or three or three (Bowel or three or three or three or three or three or the facility's "Bowel or three or	eceive and the facility must by care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced lews and record reviews the ge and implement planned to bowel elimination of thirteen (13) sampled is 9, 106 and 77). Program" revised 01/31/99 will be documented on the instration record) each shift is will be monitored each shift is following protocol will be not per MD (medical doctor) and a bowel movement in 3 agnesia (laxative) 30cc or mouth at night. Sective by 6:00 a.m. give 10mg (milligrams) ective by 10:00 a.m. give	FS	F-309 Corrective action accomplished for deficient practice residents #9, #100 educating the stat these residents, at the residents of the communicating a bowel movement #106 & #77 were ensure that bowel were happening as the second that having regular Bl had no clinical significant residents, the fact implemented these measures to ensure alleged deficient reoccur these included and second the provision of federal and state layed.	the alleged in regards to 6 & #77 by ff caring for and by educating the importance of and documenting its. Residents #9, assessed to 1 movements every three days, entions were residents at they were M's, and they gas or symptoms ring regular collity recognizes ident practices 1 to affect other allity has see additional re that the practice does not lude: mandatory nursing staff to 6 this plan of mission or truth of the facts in the statement of ion is prepared this required by the	6/25/201

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		200000000000000000000000000000000000000	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345411	B. WIN	B. WING		07/28/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			516 WA	DDRESS, CITY, STATE, ZIP CODE NLL SYREET ESVILLE, NC 28786		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECYI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	.D BE	(X5) GOMPLETION DATE
1. Resident #9 was a 02/08/08 with diagnos constipation, dementi. The most recent Minit 07/22/11 specified the long term memory im impaired cognitive ski. The MDS also specifiextensive assistance (ADLs) such as tolleti locomotion off the unit resident was frequent bladder. Resident #9's bowel of updated 07/27/11 specified from the unit resident was frequent bladder. Resident #9's bowel of updated 07/27/11 specified from the resident would have all minitarion at least excare plan intervention of the specified for side effect of the specified from the specif	rective notify medical doctor admitted to the facility on ses that included a and debility among others. Incompose that included a and debility among others. Incompose the facility among others. Incompose the facility among others. Incompose the resident and severely Its for daily decision making. It is for daily decision making	F	con agn alle des	ensure continued complete These newly implement systems changes include Coordinator reviewing documentation every 3 ensure that all residents BM's in the last nine she Additionally, Medical Fhas relocated the nurse recording from the T.A. M.A.R., and placed the bowel protocol on the N. The C.N.A.'s will recorresidents' BM's on their assignment sheets and treasignment sheets in to The nurse will review the assignment sheets and their findings. Then the assess and treat resident bowel protocol. The Decignee will monitor treasing the protocol of the planter of the monitoring for these newill continue for 6 mon however, monitor may be extended if required. The planter of the truth of egged or conclusions sot forth in the stafficiencies. The plan of correction is predor executed solely because it is required to the continue of the truth of egged or conclusions sot forth in the stafficiencies. The plan of correction is predor executed solely because it is required to the continue of the continue of the truth of egged or conclusions sot forth in the stafficiencies. The plan of correction is predor executed solely because it is required to the continue of	days to have had difts. Records BM R. to the new I.A.R. d r turn their the nurse. he C.N.A. document nurse will ts per the ON or his for further w systems ths, he	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DAYE SURVEY COMPLETED	
		345411	B. WIN	G		07/28/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				51	EET ADDRESS, CITY, SYATE, ZIP CODE 16 WALL STREET VAYNESVILLE, NC 28786		
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F 309	twelve (12) days no b documented. c. Starting on 07 five (5) days no bowe documented. A review of nursing many periods of 06/06/11 the through 06/29/11 and revealed no document constipation or impler bowel protocol for conflexible of the MAR at revealed no additionat to address the three (12). Nurse aide (NA) #1 wat 1:45 p.m. and reported that it does not a signment sheet that it does not not be added that at the beging reviewed that it are a bowel movement in the last #1 reported that if a real bowel movement in was to initiate the faciliary of the conflexible of the conflexi	owel movements were /01/11 and continuing for I movements were otes for Resident #9 for the grough 06/10/11, 06/18/11 07/01/11 through 07/05/11 tation of assessment for mentation of the facility's astipation. Ind physician orders I orders and/or interventions 3) episodes of constipation. as interviewed on 07/27/11 red she documented ements on her daily the was turned in to the lew at the end of her shift. I.m. licensed nurse (L.N) #1 reported that at the end of the nurse aide assignment of episodes of bowel residents' TARs. She monitor for adequate bowel one documented bowel one docume	F		The DON or her designer review data obtained for and trends. All data will reported to the QA&A Committee monthly for of 6 months. The QA&. Committee will evaluate effectiveness of the plan based on the outcor identified and will adjust as needed. "Preparation and/or execution of this plan correction does not constitute admission agreement by the provider of the truth of alleged or conclusions set forth in the stat deficiencies. The plan of correction is preand/or executed solely because it is require provisions of federal and state law."	patterns I be a period A the nes t the plan of or the facts ement of pared	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345411	B. WING		07/28/2011	
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F 309	TAR and reviewing the each shift to ensure the abovel movement in days). She added the licensed nurse to Initia resident had gone ninal bowel movement. On 07/28/11 at 9:20 at (DON) was interviewed #9's bowel elimination resident had not expering greater than three of the bowel protocol stated she would expering the bowel protocol stated she would expering (9) shifts without DON offered no explain bowel protocol initiate the bowel protocol initia	responsible for novements in the resident's let TAR at the beginning of the resident had experienced the last nine (9) shifts (3 at she would expect the ate the bowel protocol if a ne (9) shifts (3 days) without when the protocol is a ne (9) shifts (3 days) without when the protocol is a ne (9) shifts (3 days) without when the protocol is a ne (9) shifts (3 days) without when the protocol is a new of the protocol is a	F 309			

PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PŘÉFIX PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) YAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 7 F 309 Report (CAAs) dated 06/13/11 specified the resident had no complications from incontinence and required assistance with all toileting needs. Resident #106's bowel elimination care plan updated 06/10/11 revealed the resident had an actual alteration in bowel function and episodes of constipation. Interventions to ensure the resident would have adequate bowel elimination at least every three days to include administer medications as ordered, observe for side effects and effectiveness, and notify the MD as indicated. Resident #106's bowel elimination records were reviewed and revealed: a. Starting on 03/06/11 and continuing for seven (7) days no bowel movements were documented. A review of nursing notes for Resident #106 for the periods of 03/06/11 through 03/12/11 revealed no documentation of assessment for constipation or implementation of the facility's bowel protocol for constipation. Review of the MAR and physician orders revealed no additional orders and/or interventions to address the episode of constipation. Nurse aide (NA) #1 was interviewed on 07/27/11 at 1:45 p.m. and reported she documented residents' bowel movements on her daily assignment sheet that was turned in to the

licensed nurse for review at the end of her shift.

On 07/27/11 at 2:00 p.m. licensed nurse (LN) #1 was interviewed and reported that at the end of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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500 T/ 0/ 0	OVIDER OR SUPPLIER	HAB/WAYNESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
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F 309	sheets and transcribe movements on to the added that at the beg reviewed the TARs to elimination of at least movement in the last #1 reported that if a re a bowel movement in was to initiate the facilitiensed nurses were documenting bowel m TAR and reviewing the each shift to ensure the abowel movement in days). She added the licensed nurse to initiate resident had gone ning a bowel movement. On 07/28/11 at 9:20 at (DON) was interviewed #106's bowel eliminate the resident had not emovement in greater documentation of the initiated. She stated at licensed nurses to movements and initiate a resident went nine (movement. The DON Resident #106 had not the episode of constitution of the episode of constitution in the possible of	If the nurse aide assignment and episodes of bowel residents' TARs. She inning of her shift she inning of her shifts (3 days). LN esident had not experienced nine (9) shifts (3 days) she lility's bowel protocol. In the South Wing Unit wed and reported that responsible for novements in the resident's let TAR at the beginning of the resident had experienced the last nine (9) shifts (3 days) without the last nine (9) shifts (3 days) without are (9) shifts (3 days) without the Director of Nursing ed. She reviewed Resident ion records and confirmed experienced a bowel than three days without bowel protocol having been she would expect the unitor the TARs for bowel te the bowel protocol when 9) shifts without a bowel offered no explanation why bowel protocol initiated for	F3	309		

PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 309 Continued From page 9 F 309 07/22/08 with diagnoses that included constipation, dementia and osteoporosis among others. The most recent Minimum Data Set (MDS) 07/08/11 specified the resident had no cognitive impairment, required limited assistance with Activities, of Daily Living (ADLs) such as toileting, transfers, personal hygiene and dressing and was always continent. Record review revealed a care plan updated 07/13/11 that specified Resident #77 was at risk for constipation. The care plan specified Interventions to ensure the resident would have adequate bowel elimination every three (3) days and included to observe for bowel patterns to ensure adequate elimination and administer medications as ordered. Resident #77's bowel elimination records revealed: a. Starting on 06/09/11 and continuing for four (4) days no bowel movements were documented. b. Starting on 06/18/11 and continuing for five (5) days no bowel movements were documented. A review of nursing notes for Resident #77 for the periods of 06/09/11 through 06/12/11 and 06/18/11 through 06/22/11 revealed no documentation of assessment for constinution or

constipation.

implementation of the facility's bowel protocol for

The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 06/11 was reviewed and revealed an original physician

PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING B. WING _ 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **616 WALL STREET** BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X\$) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 309 Continued From page 10 F 309 order dated 01/13/10 for Senna (laxative) two (2) tablets twice daily for constipation. Further review of the MAR and physician orders revealed no additional orders and/or interventions to address the two (2) episodes of constipation. Nurse aide (NA) #1 was interviewed on 07/27/11 at 1:45 p.m. and reported she documented residents' bowel movements on her daily assignment sheet that was turned in to the licensed nurse for review at the end of her shift. On 07/27/11 at 2:00 p.m. licensed nurse (LN) #1 was interviewed and reported that at the end of her shift she reviewed the nurse aide assignment sheets and transcribed episodes of bowel movements on to the residents' TARs. She added that at the beginning of her shift she reviewed the TARs to monitor for adequate bowel elimination of at least one documented bowel movement in the last nine (9) shifts (3 days). LN #1 reported that if a resident had not experienced a bowel movement in nine (9) shifts (3 days) she was to initiate the facility's bowel protocol. On 07/27/11 at 2:15 p.m. the South Wing Unit Manager was interviewed and reported that licensed nurses were responsible for documenting bowel movements in the resident's TAR and reviewing the TAR at the beginning of each shift to ensure the resident had experienced a bowel movement in the last nine (9) shifts (3 days). She added that she would expect the licensed nurse to initiate the bowel protocol if a resident had gone nine (9) shifts (3 days) without a bowel movement.

On 07/28/11 at 9;20 a.m. the Director of Nursing

SYATEMENT OF DEFICIENCIES , AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345411	B. WNG	, , , , , , , , , , , , , , , , , , , 	07/28/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			8	REEY ADDRESS, CITY, STATE, ZIP CODE B16 WALL STREET NAYNESVILLE, NC 28786		
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F 431 SS=D	(DON) was interview #77's bowel eliminative the resident had not a movement in greater documentation of the initiated. She stated licensed nurses to me movements and initial a resident went nine a movement. The DON Resident #77 had not the two (2) episodes 483.60(b), (d), (e) DR LABEL/STORE DRUIT The facility must empalicensed pharmacis of records of receipt a controlled drugs in su accurate reconcillation records are in order a controlled drugs is mare conciled. Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the examplicable. In accordance with St facility must store all clocked compartments	ed. She reviewed Resident on records and confirmed experienced a bowel than three days without bowel protocol having been she would expect the onitor the TARs for bowel at the bowel protocol when (9) shifts without a bowel offered no explanation why bowel protocol initiated for of constipation. RUG RECORDS, GS & BIOLOGICALS Illoy or obtain the services of the whole establishes a system and disposition of all officient detail to enable an in; and determines that drug and that an account of all aintained and periodically expiration date when the expiration date when the drugs and biologicals in under proper temperature and authorized personnel to	F 309	F-431 Corrective action has be accomplished for the alledeficit practice by the Ur Coordinators checking almedication storage areas removing and disposing alleged expired medication and/or undated medication facility policy. As the faccognizes these alleged practices have the potent	and of all ons ons per cility deficient ial to the these assure that stice does and atory staff to ance. ems es to e areas, tts, entral expired ons. nated day of the facts	
		ide separately locked,		deficiencies. The plan of correction is prep and/or executed solely because it is requin provisions of federal and state law."	pared	

PRINTED: 08/08/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER! COMPLETED A. BUILDING B. WNG 345411 07/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SYAYE, ZIP CODE 516 WALL STREET BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE WAYNESVILLE, NC 28786 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE **PEFICIENCY**) Continued From page 12 F 431 assigned to re-check all permanently affixed compartments for storage of aforementioned locations and controlled drugs listed in Schedule II of the dispose of and re-order Comprehensive Drug Abuse Prevention and medications as needed. The nurse Control Act of 1976 and other drugs subject to will report her findings to the abuse, except when the facility uses single unit Unit Coordinator. The Unit package drug distribution systems in which the Coordinator will weekly spotquantity stored is minimal and a missing dose can check all medication storage be readily detected. areas for expired or un-dated medications. Concurrently, a sign will be posted at each This REQUIREMENT is not met as evidenced nurse's station by the Unit by: Coordinator to remind the nurses Based on observations and staff interviews, the to check all medications for facility failed to ensure that expired Tuberculin expiration dates and for dates vaccine and insulin were removed from one (1) of opened. Additionally, monthly a (2) medication room refrigerators, and failed to pharmacy representative will ensure that expired insulin was removed from check all medication storage one (1) of four (4) medication carts. areas for expired and undated medication. The Unit The findings are: Coordinator and pharmacy representative will report their 1:) A facility policy entitled Recommended findings to the DON weekly Minimum Medication Storage Parameters, dated 02/28/08, revealed that all insulin in vials, with the and/or monthly. The DON will exception of insulin detemir, should be dated take additional corrective action when opened and discarded twenty-eight days as required. Monitoring of these

FORM CMS-2507(02-99) Previous Versions Obsolete

On 07/26/11 at 2:20 p.m. an observation of the

North Wing Team One medication cart revealed

an opened, partially used, and ready for use 10 ml vial of insulin glargine. The vial was hand

On 07/26/11 at 2:44 p.m. the North Wing Unit

should be dated when opened and discarded

Manager was interviewed. She stated that insulin

dated as opened on 06/03/11.

Event ID: FNUC11

Facility ID: 623009

If continuation sheet Page 13 of 15

new system changes will continue

monitoring may be extended if

for 6 months. However,

Preparation and/or execution of this plan of

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

correction does not constitute admission or agreement by the provider of the truth of the facts

required.

provisions of federal and state law."

SELLICITOR MEDIOVIVE & MICDIOVID OF LAIDED				OMB NO. 0938-0391		
	NY OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO LOF CORRECTION LUMBER: A BUILDING		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
	12	345411	B. WING		07/28/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	ID PŘEFIX TAG	ID PROVIDER'S PLAN OF GORR PREFIX (EACH CORRECTIVE ACTION SI		(X5) COMPLETION DATE
F 431	discarded the vial of it on 07/26/11 at 3:50 p was interviewed. She nursing staff to date a and to discard them to manufacturer's recompolicy. 2.) A facility policy er Minimum Medication 02/28/08, revealed the refrigerated, dated unused portion discard on 07/26/11 at 2:16 p North Wing medication opened, partially uvial of Tuberculin vacidated as opened on 0 manufacturer's box with part: "Once entered, after 30 days." On 07/26/11 at 2:44 p Manager was intervied and discarded after the Tuberculin vaccine of the Tuberculin vaccine on 07/26/11 at 3:50 p was interviewed. She nursing staff to date Topened and to discarded after the opened and to discarded and to di	er. The Unit Manager insulin. D.m. the Director of Nursing the stated she expected foll insulin vials when opened wenty-eight days later per mendations and facility Intitled Recommended Storage Parameters, dated at Tuberculin vaccine should when opened, and the rided after thirty days. D.m. an observation of the form room refrigerator revealed issed, and ready for use 1 ml cine. The vial was hand Dich16/11. The vial was in the lith instructions which read in vial should be discarded D.m. the North Wing Unit wed. She stated that hould be dated when opened wirty days. She discarded	F4	"Preparation and/or execution of this correction does not constitute admissi agreement by the provider of the truth alleged or conclusions set forth in the deficiencies. The plan of correction is and/or executed solely because it is reprovisions of federal and state law."	for patterns nt the data to se for a The QA&A sate the lan based on and will ded.	Jos Pall

PRINTED: 08/08/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES							0: 08/08/2011
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES					APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	8	345411	B, WN	3		07/2	8/2011
NAME OF PR	OVIDER OR SUPPLIER			STRE	EY ADDRESS, CITY, STATE, ZIP CODE	1	
BRIAN CE	NTER HEALTH AND REI	HAB/WAYNESVILLE			8 Wall Syreet Aynesville, no 28786		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMAYJON)	ID PREFII TAG	`	PROVIDER'S PLAN OF CORRECT (ÉACH CORRECTIVE ACTION SHOUL OROSS-RÉFÉRENCED TO THE APPRO DEFICIENCY)	LOBE	(X5) COMPLETION DATE
F 431	Minimum Medication of 2/28/08, revealed the exception of insulin de when opened and distater. On 07/26/11 at 2:20 p North Wing medication an opened, partially undivided insulin glutis dispensed by the pharwas no date on the vibeen opened. The vibeen opened. The vibeen opened. The vibeen opened in the vibeen opened of the vibeen opened of the vibeen opened. The vibeen opened of the vi	stitled Recommended Storage Parameters, dated at all insulin in vials, with the atemir, should be dated carded twenty-eight days I.m. an observation of the n room refrigerator revealed sed, and ready for use 10 ine which had been reacy on 03/09/11. There at to indicate when it had at was in the manufacturer's which read in part: "Use pening." I.m. the North Wing Unit wed. She stated that insulin a opened and discarded r. She stated that because ed, there was no way to ired. The Unit Manager insulin. I.m. the Director of Nursing	F	131			