

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

PRINTED: 08/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2011
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/SHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to follow physician orders to check residents blood sugars and document results on flow records for one (1) of ten (10) sampled residents reviewed for medication administration. (Resident # 1)</p> <p>The findings are:</p> <p>Resident # 1 was admitted to the facility on 02/25/10 with a diagnosis of diabetes. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated on 07/14/11 revealed Resident # 1's cognition was intact.</p> <p>A review of Resident # 1's physician's monthly orders for August 2011 revealed an order to check the blood sugar by finger stick on Mondays, Wednesdays and Fridays, and document results on flow record (originally ordered on 05/05/10).</p> <p>A review of Resident # 1's Medication Administration Records and Blood Glucose Tracking Records revealed the following days when the resident's blood sugar was not checked and/or not documented on the records.</p> <p>The missing blood sugars and documentation included the following dates: July 2011 (7/1, 7/6,</p>	F 281	<p>F 281</p> <p>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1. Licensed nurse notified physician regarding missed blood sugars on 7/1, 7/6, 7/11, 7/15, 7/20, 8/3, 8/5, 8/10 and 8/12/11 and a medication variance report was completed on August 16, 2011.</p> <p>2. Current residents have the potential to be affected by the same alleged deficiency. Director of nursing (DON), Assistant Director of Nursing (ADON) conducted an audit of current residents Medication Administration Records (MAR) on August 22, 2011 to identify medications/blood sugars that were not administered as ordered. Physician was notified and medication variance report was completed for discrepancies identified.</p> <p>3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Staff Development nurse (SDC) began in service education for licensed nurses on August 15, 2011, regarding <i>Policy and Procedure for administering medications/blood sugars according to Physician orders and signing MAR after completion of orders.</i> DON, ADON, SDC began MAR audits daily on August 22, 2011 to identify missed medications/blood sugars. Physician will be notified of any discrepancies and Medication variance report will be</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kerim C. Sahwaj TITLE: Administrator (X6) DATE: 9-9-11

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.

RECEIVED
SEP 12 2011
BY: MH

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F 281	Continued From page 1 7/11, 7/15, 7/20); and August 2011 (8/3, 8/5, 8/10, 8/12). The days when the blood sugar checks were completed and documented revealed Resident # 1's blood sugars were within normal range. An interview with the Director of Nursing (DON) on 08/16/11 at 7:50 AM revealed if the medication administration and blood sugar check records were left blank, then the finger sticks were not completed. The DON further revealed the blood sugar checks should have been completed and documented as ordered. An interview with License Nurse (LN) # 1 on 08/16/11 at 10:40 AM revealed every diabetic resident should have their blood sugar checked as ordered by the physician. LN # 1 reported he should have checked and documented the results of Resident # 1's blood sugars.	F 281	completed. DON, ADON, SDC began medication pass observations for licensed nurses three times per week for four weeks then weekly ongoing, beginning August 19, 2011. 4. DON will analyze audits and medication pass observations for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that physician orders were accurately followed to monitor residents blood sugars and document the results accurately with	F 309	F 309 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #4. Director of Nursing (DON) reviewed Resident #4's Medication Administration Record (MAR) to identify missed medications/blood sugars. Physician was notified on August 16, 2011 regarding missed blood sugars and medication. Medication variance report was completed for discrepancies identified.	

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F 309	<p>Continued From page 2</p> <p>the sliding scale Insulin units administered for one (1) of ten (10) sampled residents reviewed for medication monitoring. (Resident # 4). The findings include:</p> <p>1. Resident #4 was admitted to the facility on 8/27/2010. Resident #4 's diagnoses included Diabetes Mellitus, Abnormal Glucose levels, Anoxic Brain Injury and Chronic Kidney damage.</p> <p>A review of the closed medical record of Resident #4 revealed a physician order dated 06/28/2011 to check Blood Sugar every six (6) hours and administer Novolog Sliding Scale as ordered. Resident #4 also had a scheduled order for Lantus 44 units at bedtime to control blood sugars.</p> <p>Further review of the medical record revealed that Resident #4 had fluctuating levels of Blood Sugars per physician documentation in the previous month and the physician order dated 06/28/2011 specifically indicated to check Blood Sugars at 6:00 AM, 12:00 Noon, 6:00 PM and at 12:00 midnight each day. A review of Resident #4 's Medication Administration Record (MAR) and the Blood Glucose Tracking sheet/Sliding Scale Insulin Administration Records for the month of July 2011 revealed blank spaces indicating that no blood sugar was documented and no sliding scale units of Novolog insulin administration documented.</p> <p>The missing blood sugar measurements and lack of documentation included for the following dates: 7/1/2011 at 6:00 AM and at 12:00 midnight 7/2/2011 at 6:00 AM 7/5/2011 at 12:00 midnight</p>	F 309	<p>2. Current Residents have the potential to be affected by the same alleged deficiency. Director of nursing (DON), Assistant Director of Nursing (ADON) conducted an audit of current residents Medication Administration Records (MAR) on August 22, 2011 to identify medications/blood sugars that were not administered as ordered. Physician was notified and medication variance report was completed for discrepancies identified</p> <p>3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Staff Development nurse (SDC) began in service education for licensed nurses on August 18, 2011, regarding <i>Policy and Procedure for administering medications/blood sugars according to Physician orders and signing MAR after completion of orders.</i> DON, ADON, SDC began MAR audits daily on August 22, 2011 to identify missed</p>		

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F 309	<p>Continued From page 3</p> <p>7/9/2011 at 6:00 AM and at 12:00 midnight 7/10/2011 at 12:00 midnight 7/11/2011 at 12:00 midnight 7/14/2011 at 12:00 midnight 7/15/2011 at 12:00 midnight 7/16/2011 at 12:00 midnight 7/17/2011 at 6:00 AM and at 12:00 midnight 7/18/2011 at 12:00 midnight 7/19/2011 at 12:00 midnight 7/20/2011 at 6:00 AM 7/22/2011 at 12:00 midnight 7/23/2011 at 12:00 midnight And on 7/24/2011 at 12:00 midnight.</p> <p>An interview with the Licensed Nurse (LN#2) on 8/16/2011 at 6:35 AM revealed that she was aware that Resident #4 was a brittle diabetic and his sugar was fluctuating and blood sugar had to be documented 4 times daily. LN #2 was also aware that she needed to complete two sheets related to blood sugar monitoring and the number of units of sliding scale Insulin administered. LN #2 stated that if there was no 'value' in the documentation sheet means that blood sugar level was not measured and insulin was not administered.</p> <p>An interview with the Director of Nursing (DON) on 08/16/11 at 7:50 AM revealed if the medication administration and blood sugar check records were left blank, then the Accuchecks (sugar levels) were not done. The DON further revealed the blood sugar checks should have been completed and documented as ordered.</p> <p>An interview with third shift License Nurse (LN) # 1 on 08/16/11 at 10:40 AM revealed every diabetic resident with Accucheck measurement</p>	F 309	<p>medications/blood sugars. Physician will be notified of any discrepancies and Medication variance report will be completed. DON, ADON, SDC began medication pass observations for licensed nurses three times per week for four weeks then weekly ongoing, beginning August 19, 2011.</p> <p>4. DON will analyze audits and medication pass observations for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.</p>		

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F 309	Continued From page 4 orders should have their blood sugar measurements documented and completed. LN # 1 reported that if it was blank means it was not done and LN #1 stated that he did not measure the blood glucose levels at those times for Resident #4. No further explanation was provided.	F 309	The Brian Center Nursing Care/Shamrock will be in compliance with all regulations related to the above deficiencies, F-281 and F-309 on or before September 14, 2011.		