

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

PRINTED: 03/26/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/14/2012
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & REHAB/SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 635 STATESVILLE BLVD SALISBURY, NC 28144	
(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	F 000	Resident #1 was discharged from facility to hospital on 3/5/12 with return not anticipated. Facility residents at risk for the same alleged deficient practice had a pain assessment completed by the Director of Nursing. Those residents identified with pain had physician order review to ensure a pain management plan was implemented. Systemic measures implemented to ensure the same alleged deficient practice does not recur will include: The Director of Nursing re-educating licensed staff on pain management to include resident assessment, administering medication as ordered by physician and assessing the effectiveness of medication administered. Documentation requirements were also reviewed.	4/11/12
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 staff interviews and record reviews the facility failed to assess pain, administer pain medication as ordered and monitor pain for 1 (Resident #1) of 3 residents. The findings include:  Resident #1 was admitted to the facility on 2/15/2012 with cumulative diagnoses of a left hip fracture with hemiarthroplasty (surgical repair) in December, 2011 that re fractured pathologically, Lymphoma receiving radiation, Chronic back pain and left leg deep vein thrombosis. Resident #1 was a direct admission to the hospital on 3/05/2012 due to a left hip wound.  A review of Resident #1 's admission pain medication orders dated 2/15/2012 included Fentanyl (synthetic opioid used for the treatment of chronic pain) 25 mcg (micrograms) patch topically every 72 hours and Norco (an opioid/acetaminophen pain reliever) 5/325mg (milligrams) every 6 hours as needed for pain.	F 309		

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

*Wendy S Oetinger*

TITLE

*Administrator*

(X6) DATE

*4/5/12*

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 309	<p>Continued From page 1</p> <p>The hospital order had been transcribed to a facility physician 's order sheet to be faxed to the pharmacy.</p> <p>A review of the February, 2012 Medication Administration Record (MAR) indicated that on 2/15/2012 a Fentanyl 25 mcg patch was applied topically and every 72 hours thereafter a new Fentanyl 25 mcg patch was applied. The medical record did not contain any documentation to indicate the resident 's pain assessments or monitoring of the Fentanyl patch effectiveness.</p> <p>The MAR review also revealed that Resident #1 was to be given Lortab 5/500 mg every 6 hours as needed from " EKit " (facility medication backup) until Norco 5/325mg was available and then discontinue the Lortab. The MAR had 2 untimed entries that indicated the resident received 2 doses of Lortab 5/500 on 2/15/2012. The medical record did not contain any documentation to indicate the resident 's pain location, intensity or effectiveness of the medication administered.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 3/05/2012 indicated that Resident #1 was able to make himself understood and understood others. Resident #1 did not have long term or short term memory problems and his cognition was intact.</p> <p>The Pain Assessment Interview section of the MDS assessment indicated that Resident #1 had pain frequently that effected sleep at night. The interview indicated that the pain intensity was 9 on a 1-10 pain scale where 10 was the most intense pain imaginable.</p>	F 309	<p>The Director of Nursing or Unit Managers/Coordinator will conduct weekly audits times 4 weeks of 2-4 random sample residents identified with physician orders for pain medication to ensure resident assessment, pain medication was administered timely and the effectiveness of the medication was monitored and documented. The results of these audits will be reviewed during the Interdisciplinary Team meeting weekly times 4 weeks. Negative findings will be addressed when identified. The Director of Nursing will report the results of the pain management audits to the Quality Assessment and Assurance Committee Monthly times 3 months. The Committee will evaluate the effectiveness of the plan based on trends identified additional interventions will be developed and implemented as needed.</p>	

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F 309	<p>Continued From page 2</p> <p>The Pain care plan dated 3/05/2012 indicated the resident ' s pain was related to chronic disease process, fractured left hip, neuropathic pain and chronic back pain. The set goals were that the resident would have reduced pain, an increase in ADL (activities of daily living) abilities and would verbally express increased satisfaction with pain control. The interventions to achieve the goals included positioning and support, relaxation, administration of analgesics as ordered, implementation of the pain management flow sheet, observe resident for signs and symptoms of pain , including verbal expressions and non verbal expressions (facial grimacing, bracing, restlessness, rubbing) frequency of monitoring every 4-6 hours, notification of the physician if interventions were not consistently effective, and to medicate the resident for pain prior to treatments and therapy, if indicated.</p> <p>A Nurses note dated 2/16/2012 at 10:30am read, " Resident taken to (name of facility) for radiation at 10:00 without Nurse being notified. Resident was brought back with out treatment being done because of being in extreme pain. " The Nurse documented that the resident was medicated with Norco 5/325 mg for pain at 10:30 am. The radiation facility called and said they needed the resident back at 1pm for his treatment but the Nurse documented that the resident did not want to go back that day. The Nurse documented on 2/16/2012 at 1:20 pm a new order was received for Dilaudid (pain reliever 5-8 times more potent than Morphine) 4 mg every 2 hours as needed for pain. The family and the resident were aware and in agreement with the new order.</p>	F 309		

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F 309	<p>Continued From page 3</p> <p>An interview was conducted on 3/13/2012 at 11:25am with Nurse #1. She said that she worked with the resident regularly on day shift. She said the resident was always in a lot of pain. Nurse #1 said when Resident #1 opened his eyes he wanted 4mg of Dilaudid. Nurse #1 said even though it was not documented the Norco 5/325 mg did not work for Resident #1. Nurse #1 said she was sure the Physician was aware.</p> <p>The Physician 's Telephone orders sheet dated 2/16/2012 and timed at 12:45pm included an order for Norco 5/325 mg every 4 hours for pain. The order included an extra dose of Norco 5/325 mg to be administered prior to leaving for radiation treatments.</p> <p>A telephone interview with Nurse #2 was conducted on 3/13/2012 at 4pm. Nurse #2 said that pain medication was administered on one of the days she worked over the weekend or 3/03/2012 or 3/04/2012. Nurse #2 said she could recall that Resident #1 was out of the facility all day and when he returned he was in pain. Nurse #2 said the resident was medicated once or maybe twice she could not recall. The Nurse said the resident was usually medicated every 2 hours with Dilaudid. She said if anything unusual occurred during her shift she charted it in the chart or on the 24 hour report.</p> <p>The Nurses Notes and the MAR and did not contain any documentation to indicate any pain assessments or that Dilaudid or Norco was administered at all on 3/03/2012 or 3/04/2012.</p> <p>An interview on 3/13/2012 at 4:30 pm was conducted with the Director of Nursing (DON). The DON said that she would expect the Nurses to administer medications as ordered or call for</p>	F 309		

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F 309	Continued From page 4 more orders if the medications were not providing pain relief. The DON said she expects the Nurses to document resident assessments on the proper forms or in their Nurses Notes. The DON said the facility does not share the 24 hour report but she would review it for any doses of pain medication administration or resident assessments for Resident #1.	F 309		