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 06/21/2012

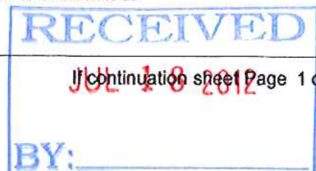
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SPRUC	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(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 investigaion survey of 06/21/2012. Event ID #ZPSC11.	F 000		7-13-2012
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 follow a physician order for one (1) of fifteen (15) sampled residents reviewed for medication administration. (Resident # 198) The findings are: Resident # 198 was admitted to the facility with diagnoses including Gastric Ulcer Disease and Gastrointestinal Hemorrhage. A review of Resident #198's medical record revealed the admission orders dated 6/11/2012 included an order for the resident to have hemoccult stools x 3, (test for the presence of blood in stool). A review of all sections of the medical record revealed no documentation the hemoccult tests were done. On 6/21/2012 at 1:40 PM Licensed Nurse (LN) #3 was interviewed and resident #198's chart and Medication Administration Record (MAR) reviewed. LN #3 revealed there was no documentation the hemoccults had been done or	F 281	F281 1. The following corrective actions have been taken: Corrective action was accomplished in regard to the alleged deficient practice relating to resident #198. (Completion date June 27, 2012) MD notified with new orders received on 6/22/12 to obtain hemoccult stools x 3. Resident # 198 had hemoccult stool testing on 6/24/12, 6/26/12, and 6/27/12 with negative results from all three stools. RCS (CNA) were informed about the need for stool specimen for testing via vital sign assignment sheets daily until testing was completed. Communication between nurses was accomplished by writing need for stool specimen on the 24 hour report sheet to be passed on to the oncoming staff nurses. 2. Residents with the potential to be affected by this alleged deficient practice:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7-16-12

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.

original signature 7/11/12 mh



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

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F 281	Continued From page 1 attempted and confirmed she had not been informed by anyone or had knowledge the hemoccult tests had been ordered On 6/21/2012 at 1:50 PM LN #4 was interviewed and resident # 198's bowel record was reviewed. LN #4 revealed Resident #198 used the bedpan and bedside commode and the records documented there had been at least four (4) opportunities to collect a stool specimen since the order was received. LN #4 stated the facility procedure was to let the Nursing Assistant's (NA) know when a hemoccult was ordered and they would save the stool specimen for the nurse who would use the onsite facility equipment and perform the test. LN #4 confirmed she was unable to find documentation the hemoccult tests had been done and stated the staff just did not know the hemoccults were ordered. LN #4 reported the staff member who had received the order was unavailable for interview. On 6/21/2012 at 2:00 PM, NA #1, who worked with Resident # 198, revealed she was not aware the Resident had a hemoccult test ordered. She confirmed she had done them in the past with other residents and the usual procedure was for the charge nurse to tell her or write it on the work sheet and that had not been done. NA #1 stated Resident #198 was weight bearing as tolerated and had to be helped to the bathroom. On 6/21/2012 at 2:05 PM the Director of Nurses (DON) was interviewed and revealed her expectations were the nurses would inform NA staff when a specimen was required for testing and follow the facility procedure to save the stool specimen and then go get the nurse. The DON	F 281	The Nurse management of the facility completed as audit of all charts from June 1, 2012 forward to June 21, 2012 to identify any orders for hemoccult stools. 3. Measures put into place to ensure the alleged deficient practice does not recur include (by June 20,2012) The DON/designee will re-educate nursing staff on following MD orders for hemoccult stools. (completed on 7/2/12 and 7/3/12) . Nurses will communicate to RCS (CNA) via assignment sheets q shift of any special needs (ie stool specimen for resident) The DON/designee will randomly monitor 5 charts weekly for period of 4 weeks to identify follow up needs of hemoccult stools. The results of this monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting for 3 months then quarterly as needed. The Committee will evaluate and make further recommendations as indicated. *Preparation and/or execution of this plan of correction do 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 federal and state law requires it.*	

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F 281	Continued From page 2 stated communication was the problem.	F 281		