

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

PRINTED: 07/26/20
FORM APPROVE
OMB NO. 0938-03

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 07/12/2012
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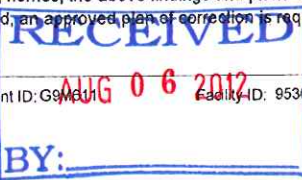
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/SHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide privacy while providing care to one (1) of five (5) sampled residents (Resident #113).</p> <p>The findings are: Resident #113 was admitted to the facility with diagnoses including Neurogenic Bladder and</p>	F 164	<p>F 164</p> <p>Director of Nursing (DON), Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) provided in service education for staff regarding "Providing Privacy during care" beginning on 7/16/12.</p> <p>Facility residents have the potential to be affected by the alleged deficient practice. DON, ADON and SDC began in service education for facility staff on 7/16/12, regarding "Providing Privacy during care." DON, ADON and SDC began observations during resident care to assure privacy was provided on 7/17/12 for three staff members per week for four weeks then two staff members weekly ongoing.</p> <p>DON, ADON and SDC began in service education for facility staff on 7/16/12, regarding "Providing Privacy during care." In service will be provided to newly hired</p> <p>"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."</p>	8/7/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathryn B. Saithes</i>	TITLE <i>Interim Administrator</i>	(X6) DATE <i>8/3/12</i>
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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 164	Continued From page 1 Urinary Retention. A quarterly Minimum Data Set (MDS) assessment dated 03/20/12 revealed Resident #113 required extensive assistance with activities of daily living and was able to make her needs known. The MDS further revealed Resident #113 had an indwelling urinary catheter. On 07/11/12 at 2:30 PM nursing assistant (NA) #4 provided incontinence care to Resident #113. Immediately following the incontinence care, Licensed Nurse (LN) #3 placed an indwelling urinary catheter in Resident #113's bladder. During the procedures, Resident # 113 was exposed from the waist down. Resident #113's bed was located next to the window with the window blind opened and raised approximately ten inches. Located outside the window were two storage sheds. On 07/11/12 at 3:40 PM LN #3 was interviewed. LN #3 revealed the blinds covering the window should have been closed to provide privacy to Resident #113 during care. An interview with the Director of Nursing (DON) on 07/12/12 at 3:15 PM revealed she expected staff to provide privacy by closing window blinds, closing the door and pulling the privacy curtain when providing care to a resident.	F 164	staff during orientation. DON, ADON and SDC began observations during resident care to assure privacy was provided on 7/16/12, for three staff members per week for four weeks then two staff members weekly ongoing. Administrator and Don will identify trends or patterns and bring to QA&A weekly for four weeks then monthly thereafter. QA&A committee will evaluate the effectiveness of the plan based trends identified and adjust the plan as necessary.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	"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."	

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F 279	<p>Continued From page 2 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan for one (1) of three (3) sampled residents with an indwelling urinary catheter (Resident #23).</p> <p>The findings are:</p> <p>Medical record review revealed Resident #23 was admitted to the facility with diagnoses including Benign Prostatic Hyperplasia and Dementia. A significant change Minimum Data Set (MDS) assessment dated 03/11/12 indicated Resident #23 had moderately impaired cognitive skills for daily decision making and required extensive to total assistance with activities of daily living (ADL). The MDS further revealed Resident #23 was frequently incontinent with bowel and bladder.</p> <p>A nursing care plan dated 11/18/11 was reviewed and revealed Resident #23 was care planned for urinary incontinence. A quarterly review of the care plan dated 02/21/12 indicated continue plan of care for ninety (90) days. On 04/24/12 an entry on the care plan revealed "has Foley catheter, continue with plan of care for 90 days."</p>	F 279	<p>F 279</p> <p>The Resident Care Management Director (RCMD) developed a care plan for the indwelling urinary catheter for Resident #23 on 7/12/12.</p> <p>The RCMD identified residents with orders for indwelling urinary catheter to validate that each resident had a care plan for the indwelling urinary catheter. The RCMD identified 9 residents with orders for indwelling urinary catheter and each resident had a care plan for the indwelling catheter.</p> <p>The Staff Development Coordinator (SDC) and RCMD began in service education on 7/16/12 for the licensed nurses regarding initiation of care plan for indwelling urinary catheter when physician orders are received. Director of Nursing (DON), Assistant Director of Nursing (ADON), and SDC will review telephone orders daily Monday through Friday beginning 7/16/12 to identify residents with orders for</p> <p>"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."</p>	8/7/12

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F 279	Continued From page 3 On 06/04/12 an entry on the care plan revealed "has Foley catheter, continue with plan of care for 90 days." A physician order dated 04/17/12 revealed Resident #23 was re-admitted on 04/17/12 with an indwelling urinary catheter secondary to bladder outlet obstruction. On 07/12/12 at 1:10 PM the MDS coordinator was interviewed and revealed Resident #23 should have been care planned for indwelling urinary catheter in April 2012 on his return to the facility with the catheter. An interview with the Director of Nursing (DON) on 07/12/12 at 3:15 PM revealed a nursing care plan for indwelling urinary catheter should have been implemented when Resident #23 returned from the hospital with a catheter in place.	F 279	indwelling urinary catheter. DON, ADON and/or SDC will audit the resident chart to validate that a care plan was initiated for the indwelling urinary catheter. The licensed nurse will update the care plan quarterly, annually and with any significant change. The DON/ADON/SDC will review documentation of audits and identify patterns or trends and report trends in Quality Assessment and Assurance (QAA) committee weekly for 4 weeks then monthly thereafter. The QAA committee will evaluate the effectiveness of the above plan and adjust the plan based on trends identified.	
F 312 SS=E	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 rinse the perineal area following incontinence care (Resident #4), remove facial hair (Resident #11) and provide nail care (Residents #110 and #124) for four (4) of six (6) sampled residents. The findings are: 1. Resident #4 was admitted to the facility with	F 312	"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."	

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F 312	<p>Continued From page 4</p> <p>diagnoses including Heart Failure, Hypertension and Diabetes.</p> <p>A Minimum Data Set (MDS) assessment, a quarterly, dated 05/04/12 revealed Resident #4 was completely dependent on staff for toilet use and required extensive assistance with personal hygiene. The MDS further indicated Resident #4 was able to make her needs known.</p> <p>A shampoo and body wash product used by the facility contained the following instructions for use; "apply, rinse thoroughly and pat dry."</p> <p>On 07/11/12 at 11:00 AM an observation was made of nursing assistant (NA) #4 providing incontinence care to Resident #4. NA #4 prepared two (2) basins of water. In one basin NA #4 added a shampoo and body wash product which produced suds and a second basin contained plain water. Using a wash cloth, NA #4 washed Resident #4's perineal area with the water containing the shampoo and body wash. NA #4 placed the wash cloth back in the basin containing the shampoo and body wash and re-washed the resident. Without rinsing the resident with the plain water, NA #4 dried the resident, applied a barrier cream to the perineum and placed a clean brief on Resident #4.</p> <p>An interview with NA #4 on 07/11/12 at 11:15 AM revealed the basin of plain water was for use if the resident had a bowel movement. NA #4 acknowledged the shampoo and body wash product required rinsing. NA #4 stated he had rinsed Resident #4, but "it must have been the soapy water and not the clean water in the basin."</p> <p>An interview with the Director of Nursing (DON) on 07/12/12 at 3:15 PM revealed NA's are expected to rinse the shampoo/body wash</p>	F 312	<p>F 312</p> <p>The licensed nurse assessed Resident #4's peri area for redness or irritation on 7/12/12. No redness or irritation noted. The Staff Development Coordinator (SDC) began in service education on 7/16/12 for nursing staff regarding procedure for providing incontinence care, which includes cleansing and rinsing. The nursing assistant shaved Resident #11's facial hair on 7/12/12. The SDC began in service education on 7/16/12 for nursing staff regarding "Providing assistance for dependent residents with ADL's which includes shaving of facial hairs." The licensed nurse provided nail care for Resident #110 and Resident #124 on 7/12/12. The SDC began in service education on 7/16/12 for nursing staff regarding "Providing assistance for dependant residents with ADL's which includes nail care." The Director of Nursing (DON), Assistant Director of Nursing (ADON) identified residents that</p> <p>"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."</p>	8/7/12	

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F 312	<p>Continued From page 5</p> <p>product from the resident's skin. The DON further revealed two basins of water should be available when providing incontinence care; one with the body wash product for washing and one with plain water for rinsing.</p> <p>2. Resident #11 was admitted to the facility on 3/29/06 with diagnoses of Vascular Dementia, Hypertension, Alzheimer's Disease, and abnormal posture.</p> <p>The most recent Minimum Data Set (MDS) dated 5/30/12 specified the resident was severely cognitively impaired and was totally dependent on staff for completion of all Activities of Daily Living (ADL) including personal hygiene. The MDS also specified the resident did not reject care.</p> <p>Review of Resident #11's medical record revealed a care plan updated 5/30/12 related to ADL care that specified the resident continued to require total assistance with ADLs.</p> <p>On 07/09/12 at 12:24 PM, Resident #11 was observed sitting in a wheelchair in the room with several white curly chin hairs noted. On 7/10/12 at 4:28 PM the resident was again observed laying in bed asleep with several white curly chin hairs noted. Subsequent observations of Resident #11 on 7/11/12 at 10:18 AM, 11:03 AM and 12:22 PM revealed that Resident #11 continued to have several white curly chin hairs.</p> <p>Interview with the nursing assistant (NA) #1 on 7/11/12 at 2:12 PM revealed she would be informed of the care needed for residents by viewing the NA daily care sheet, and report received from the charge nurse at the beginning of each shift. NA #1 stated Resident #11</p>	F 312	<p>are dependent on staff to provide Activities of Daily Living (ADL). The DON and ADON observed identified residents for grooming needs on 7/16/12. Residents identified with grooming needs were provided assistance when they were identified. The SDC began in service education on 7/16/12 for nursing staff regarding "Providing assistance for dependent residents with ADL's which includes grooming and incontinence care."</p> <p>The DON, ADON and SDC will observe nursing staff while providing incontinence care and grooming needs for five residents weekly for four weeks then two residents weekly ongoing. The SDC began in service education on 7/16/12 for nursing staff regarding "Providing assistance for dependent residents with ADL's which includes grooming and incontinence care." In service education will be provided for newly hired nursing staff during new hire orientation.</p> <p>"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."</p>	

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F 312	<p>Continued From page 6</p> <p>received showers on Wednesday's and Friday's and confirmed Resident #11 had received a shower on Wednesday, 7/11/12. NA #1 reported she had noticed Resident #11's facial hair on 07/10/12 and thought the shower team would remove it during her shower on 7/11/12.</p> <p>On 7/12/12 at 2:35 PM the DON was interviewed and stated she expected NAs to remove facial hair when it was observed or at least offer. She further stated that while the shower team can perform care to remove facial hair, it would be the responsibility of the NA that is assigned to the resident.</p> <p>3. Resident #110 was admitted to the facility with diagnoses including Cerebral Vascular Accident (CVA) and Diabetes Mellitus.</p> <p>A Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) Functional dated 01/17/12 revealed Resident #110 had right sided weakness due to a past CVA and required extensive assistance for ADL needs.</p> <p>A quarterly Minimum Data Set (MDS) dated 04/05/12 revealed Resident #110 was cognitively intact and required extensive assistance for personal hygiene. The quarterly MDS also noted Resident #110 had impaired range of motion of the upper and lower extremity on one side of his body.</p> <p>The care plan for ADL, last updated on 07/12/12, indicated Resident #110 required extensive assistance for the completion of ADL needs. The goal was for Resident #110 to have his ADL needs met with staff assistance and intervention while maintaining the highest level of independent function possible.</p>	F 312	<p>DON will identify any trends or patterns identified during audits and observations and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified</p> <p>" 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."</p>	

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F 312	<p>Continued From page 7</p> <p>Initial observations of Resident #110 on 07/09/12 at 12:15 PM revealed all ten fingernails extended approximately 1/8 of an inch beyond his fingertips. His right arm rested in a fleece lined trough attached to the arm of his wheel chair. Subsequent observations of Resident #110 on 07/10/12 at 8:20 AM and 07/11/12 at 5:15 PM revealed revealed all ten fingernails extended approximately 1/8 of an inch beyond his fingertips.</p> <p>During a resident interview on 07/09/12 at 3:35 PM Resident #110 stated his fingernails were too long and he would like to have them trimmed. Resident could not recall if he had asked anyone to trim his fingernails.</p> <p>Interview with nursing assistant (NA) #2 on 07/12/12 at 12:05 PM revealed she cleaned under Resident #110's fingernails 07/10/12 during his shower but did not trim his finger nails because NAs were not allowed to trim Diabetic residents fingernails or toenails. NA #2 further stated she would sometimes tell the licensed nurse (LN) when she noticed a Diabetic residents fingernails needed to be trimmed.</p> <p>During an interview on 07/12/12 at 2:15 PM LN #1 stated she did not know who was responsible for trimming Diabetic residents fingernails and would need to ask the Director of Nursing (DON).</p> <p>On 07/12/12 at 2:25 PM the DON observed Resident #110's fingernails and agreed they needed to be trimmed. During a follow up interview on 07/12/12 at 2:30 PM the DON stated she expected anyone who cared for a resident and noticed nail care was needed to provide such or report to the LN if the resident was Diabetic.</p> <p>4. Resident #124 was admitted to the facility</p>	F 312	<p>"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."</p>		

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F 312	<p>Continued From page 8</p> <p>with diagnoses including Dementia and Diabetes Mellitus. The admission Minimum Data Set (MDS) dated 05/08/12 revealed Resident #124 had short and long-term memory problems and moderately impaired cognitive skills for daily decision making. The admission MDS noted Resident #124 required extensive assistance for personal hygiene.</p> <p>The Care Area Assessment Summary for Activities of Daily Living (ADL) Functional dated 05/08/12 stated Resident #124 had severe cognitive impairment and staff would need to anticipate her needs.</p> <p>The care plan for ADL, dated 05/08/12, indicated Resident #124 required extensive assistance for the completion of ADL needs. The goal was for Resident #124 to have her ADL needs met with staff assistance and intervention while maintaining the highest level of independent function possible.</p> <p>Initial observations of Resident #124 on 07/09/12 at 5:00 PM revealed all ten fingernails extended at least 1/8 of an inch beyond her fingertips and both thumbnails were jagged. Subsequent observations of Resident #124 on 07/11/12 at 5:30 PM and 07/12/12 at 11:00 AM revealed revealed all ten fingernails extended at least 1/8 of an inch beyond her fingertips and both thumbnails were jagged.</p> <p>Interview with nursing assistant (NA) #2 on 07/12/12 at 12:05 PM revealed she cleaned under Resident #124's fingernails 07/10/12 during her shower but did not trim her fingernails because NAs were not allowed to trim Diabetic residents fingernails or toenails. NA #2 further stated she would sometimes tell the licensed nurse (LN) when she noticed a Diabetic residents fingernails needed to be trimmed.</p>	F 312	<p>" 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."</p>		

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

PRINTED: 07/26/20
FORM APPROVE
OMB NO. 0938-039

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 07/12/2012
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/SHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 2727 SHAMROCK DRIVE CHARLOTTE, NC 28205	
(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 312	Continued From page 9 During an interview on 07/12/12 at 2:15 PM LN #1 stated she did not know who was responsible for trimming Diabetic resident's fingernails and would need to ask the Director of Nursing (DON). On 07/12/12 at 2:20 PM the DON observed Resident #124's fingernails and agreed they needed to be trimmed. During a follow up interview on 07/12/12 at 2:30 PM the DON stated she expected anyone who cared for a resident and noticed nail care was needed to provide such or report to the LN if the resident was Diabetic.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to secure a urinary catheter to prevent excessive tension on the catheter for three (3) of three (3) sampled residents. (Residents #113, #37 and #23). The findings are: 1. Resident #113 was admitted to the facility with diagnoses including Neurogenic Bladder and Urinary Retention. The most recent Minimum	F 315	"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."	

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F 315	<p>Continued From page 10</p> <p>Data Set (MDS) assessment, a quarterly review, dated 03/20/12 revealed Resident #113 required extensive assistance with activities of daily living and was able to make her needs known. The MDS further revealed Resident #113 had an indwelling urinary catheter.</p> <p>A nursing care plan dated 01/22/12 for indwelling catheter included the following intervention; anchor catheter to prevent excessive tension.</p> <p>During an observation on 07/11/12 at 2:30 PM Licensed Nurse (LN) #3 placed an indwelling urinary catheter in Resident #113's bladder. After the procedure LN #3 failed to anchor the catheter to prevent excessive tension against the resident's bladder.</p> <p>An observation of the supply closet on 07/12/12 at 1:08 PM revealed a box of catheter secure strips located adjacent to the indwelling urinary catheter supplies for resident use.</p> <p>During an interview on 07/12/12 at 2:15 PM LN #3 confirmed she did not anchor the resident 's catheter after it was placed on 07/12/12.</p> <p>An interview with the Director of Nursing (DON) on 07/12/12 at 3:30 PM revealed she expected nursing staff to secure the tubing on residents who had indwelling urinary catheters. The DON further revealed care plans for urinary indwelling catheters indicated tubing is to be anchored and catheter secure strips were located in the supply closet.</p> <p>2. Resident #37 was admitted to the facility with diagnoses including Diabetes, Hypertension and Depression. A Minimum Data Set (MDS) dated 06/01/12 revealed Resident #37 required extensive assistance with activities of daily living</p>	F 315	<p>F 315</p> <p>The licensed nurse secured the indwelling urinary catheter tubing for residents # 113,37 and 23, on 7/14/12, using the secure straps available at the facility.</p> <p>The Director of Nursing (DON) and Assistant Director of Nursing (ADON) identified residents with orders for indwelling urinary catheter. The DON and ADON observed identified residents on 7/15/12 to assure indwelling urinary catheter tubing was secured using the secure straps. 9 residents were identified and the indwelling urinary catheter tubing was secured using the secure straps on 7/15/12. The Staff Development coordinator (SDC) began in service education for nursing staff on 7/14/12, regarding securing indwelling urinary catheter tubing with the secure straps.</p> <p>The DON, ADON, SDC and RN supervisors will observe identified residents daily for two</p> <p>“ 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.”</p>	8/7/12

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F 315	<p>Continued From page 11 (ADL). The MDS further revealed Resident #37 had an indwelling urinary catheter.</p> <p>A nursing care plan dated 01/09/12 for indwelling catheter included the following intervention; anchor catheter to prevent excessive tension.</p> <p>An observation on 07/12/12 at 1:00 PM revealed Resident #37's indwelling urinary catheter was not anchored to prevent excessive tension against the resident ' s bladder.</p> <p>An observation of the supply closet on 07/12/12 at 1:08 PM revealed a box of catheter secure strips located adjacent to the indwelling urinary catheter supplies for resident use.</p> <p>An interview with the Director of Nursing (DON) on 07/12/12 at 3:30 PM revealed she expected nursing staff to secure the tubing on residents who had indwelling urinary catheters. The DON further revealed care plans for urinary indwelling catheters indicated tubing is to be anchored and catheter secure strips were located in the supply closet.</p> <p>3. Medical record review revealed Resident #23 was admitted to the facility with diagnoses including Benign Prostatic Hyperplasia, Diabetes and Dementia. A significant change Minimum Data Set (MDS) assessment dated 03/11/12 indicated Resident #23 had moderately impaired cognitive skills for daily decision making and required extensive to total assistance with activities of daily living (ADL).</p> <p>Medical record review further revealed Resident #23 returned to the facility from an acute care hospital on 04/17/12 with an indwelling urinary catheter.</p> <p>On 07/12/12 at 11:00 AM catheter care for</p>	F 315	<p>weeks then weekly ongoing to assure secure straps are used to secure indwelling urinary catheter tubing. The DON, ADON and SDC will review telephone orders daily Monday through Friday to identify new orders for indwelling urinary catheter and will observe to assure secure straps are utilized. The SDC began in service education for nursing staff on 7/14/12, regarding securing indwelling urinary catheter tubing with the secure straps. In service education will be provided for newly hired nursing staff during new hire orientation.</p> <p>DON will identify any trends or patterns identified during audits and observations and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified</p> <p>“ 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.”</p>		

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F 315	Continued From page 12 Resident #23 was observed. During the procedure it was noted that Resident #23's indwelling urinary catheter was not anchored to prevent excessive tension. An observation of the supply closet on 07/12/12 at 1:08 PM revealed a box of catheter secure strips located adjacent to the indwelling urinary catheter supplies for resident use. An interview with the Director of Nursing (DON) on 07/12/12 at 3:30 PM revealed she expected nursing staff to secure the tubing on residents who had indwelling urinary catheters. The DON further revealed care plans for urinary indwelling catheters indicated tubing is to be anchored and catheter secure strips were located in the supply closet.	F 315			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to secure a compressed oxygen cylinder during transport during one (1) of two (2) observations. The findings are:	F 328	F 328 The Staff Development Coordinator (SDC) and the Maintenance director provided one to one in service education on 7/11/12, regarding safe storage and transporting oxygen, for the staff member observed carrying the compressed oxygen cylinder. [" 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."]	8/7/12	

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F 328	Continued From page 13 On 7/11/12 at 9:25 AM nursing assistant (NA) #1 was observed carrying a compressed oxygen cylinder tank approximately 62 feet down the 200 Hall from the oxygen storage closet to the rehab gym. She was interviewed at this time and reported the tank was full and it was her usual practice to carry an oxygen cylinder tank with one hand fastened on the bottom of the tank, the other hand grasped around the stem of the tank and held next to her person. NA #1 was interviewed and reported she was not aware she needed to use a canister cart (a device used to secure cylinders for transport) for transporting an oxygen cylinder tank. She was unable to recall training on the safe transport of oxygen cylinder tanks. On 7/11/12 at 9:30 AM the oxygen storage closet was observed and revealed seven (7) available canister carts. On 7/11/12 at 9:45 AM the Director of Nursing (DON) was interviewed and reported she expected staff to use a canister cart to secure an oxygen cylinder tank for transportation. She added all staff attended mandatory annual training on the safe practice of oxygen tanks. On 7/11/12 at 10:30 AM the Staff Development Coordinator (SDC) was interviewed and reported staff were trained to secure oxygen cylinder tanks in a cart for any transfer. She added that in-services on the safe storage/transportation of oxygen tanks was mandatory and held on an annual basis. The SDC reported she was new to her position and was unaware of when the prior training was held. The SDC presented documentation that specified NA #1 received training on occupational and safety hazards on 6/14/12 which would have included the proper transportation of oxygen cylinder tanks.	F 328	The SDC and Maintenance director began re-education on 7/11/12 for facility staff regarding "Safe storage and transport of oxygen." The Director of Nursing (DON), SDC and Maintenance director identified residents that receive oxygen and observed those residents oxygen cylinders to assure the cylinders were secured per policy. The Department Managers will observe oxygen cylinders during daily rounds to assure cylinders are secured according to policy. The SDC and Maintenance director began in service education for facility staff on 7/11/12 regarding "Safe storage and transport of oxygen." The in service education will be provided during new hire orientation, annually and as necessary. The Administrator will identify any trends or patterns identified during rounds and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified "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."		

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F 328	Continued From page 14	F 328	F 329		
F 329 SS=D	<p>On 7/11/12 at 10:45 AM the Maintenance Director was interviewed and reported he was responsible for providing a mandatory occupational and safety hazard training that included the proper transportation of oxygen cylinders. He specified that a tank was to be secured in a cart during a transfer. He verified that staff should never transport a tank in their hands. The Maintenance Director added NA #1 had received training and was aware of facility procedure.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 329	<p>The licensed nurse notified physician on 7/11/12 regarding the order for the HgbA1c for Resident #74. New order was received and written on 7/11/12 to obtain HgbA1c every 6months. Hgb A1c was obtained on 7/12/12 and physician was notified on 7/11/12.</p> <p>The Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Staff Development Coordinator (SDC) performed a lab audit of current facility residents on 7/30/12, to assure labs were obtained per physician orders. Physician was notified regarding discrepancies identified and new orders were written as necessary. The DON, ADON and SDC identified residents with orders for antipsychotic medications on 8/3/12, to review the monitoring and necessary use of the medication. The physician was notified of any concerns when identified. The SDC began in service education on 7/16 for the licensed nurses regarding "Obtaining labs per physician orders and monitoring the use of unnecessary medications."</p> <p>"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."</p>	8/7/12	

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F 329	<p>Continued From page 15</p> <p>by: Based on staff interviews and record reviews the facility failed to ensure laboratory tests were performed as ordered for one (1) of ten (10) residents sampled for unnecessary medication review. (Resident #74)</p> <p>The findings are:</p> <p>Resident #74 was admitted to the facility on 12/31/08 with a diagnosis of Alzheimer's Disease and Dementia without Behavior Disturbance, Psychosis, Schizophrenia, and Anxiety Disorder.</p> <p>Review of Resident #74's medical record revealed a July 2012 physician order sheet that requested a Hemoglobin (Hgb) A1c lab be performed every three months (January, April, July, and October). The pharmacy review dated 6/25/12 documented that the resident had been prescribed the medication Seroquel (an anti psychotic) since 2/13/11. Upon further review of Resident #11's record, it was discovered that the last HgbA1c lab had been performed on 01/17/12.</p> <p>On 7/11/12 at 10:35 AM an interview was conducted with the Director of Nursing (DON). She stated that she and the licensed nurses were responsible for reviewing physician's orders and the monthly physicians order sheet for accuracy. She reported that Resident #74 was not diabetic and the physician ordered the HgbA1c lab for monitoring because of the prescription for Seroquel (an antipsychotic medication). She stated Seroquel can cause blood sugar levels to be elevated. The DON further stated she expect physician's orders to be followed and could not explain why Resident #74 did not have a HgbA1c drawn in April 2012.</p> <p>During an interview with the Medical Director</p>	F 329	<p>The DON, ADON and SDC will review telephone orders daily Monday through Friday to identify orders for antipsychotic medications and assure appropriate monitoring of medications. The pharmacist will review resident charts monthly and will communicate with physician recommendations for lab monitoring and gradual dosage reductions for antipsychotic medications. The DON will review pharmacist recommendations monthly and follow up with physician for new orders and dosage reductions. The SDC began in service education for licensed nurses on 7/16/12 regarding "Obtaining labs per physician orders and monitoring the use of unnecessary medications."</p> <p>DON will identify any trends or patterns identified during audits and reviews and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified.</p> <p>"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."</p>	

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F 329	Continued From page 16 (MD) on 7/11/12 at 11:26 AM, he stated that Resident #74's HgbA1c lab was ordered because of the prescribed medication Seroquel. Rather than check it frequently, he stated it was only necessary to monitor HgbA1c every three (3) months to ensure that she is not developing Diabetes. The physician further stated Resident #74's HgbA1c level could be monitored every six (6) months because the previous HgbA1c results were within normal limits on 01/17/12.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and documentation review the facility failed to store frozen items at or below zero (0) degrees Fahrenheit and failed to properly sanitize utensils prior to use. In addition, the facility failed to serve a resident a meal tray prior to placing dirty trays on the tray cart during one (1) of three (3) meal observations (Resident #8). The findings are: 1. An initial tour of the kitchen was made on 7/9/12 at 10:30 AM. The facility did not have a Dietary Manager (DM) but a DM for the facility's corporation was present for the tour.	F 371	F 371 The Administrator ordered a freezer trailer to be used for the frozen food until the facility freezer was repaired. A freezer trailer arrived on 7/9/12 and the frozen food was transferred into the freezer trailer by the dietary staff. The facility freezer was repaired on 7/13/2012 by Eastern Refrigeration Service. The Dietary manager (DM) replaced the sanitizer with a new container on 7/11/12. The sanitizer was tested by the Dietary manager on 7/11/12 after the replacement container and results were >200ppm. The DM began in service education for the dietary staff on 7/12/12 regarding "Monitoring refrigerator/freezer temperatures and testing sanitizer in 3 compartment sink prior to use. Recommended temperature ranges and sanitizer range and procedure for correcting abnormal readings." The Staff development coordinator (SDC) began in service education on 7/16/2012 for nursing staff regarding meal tray storage and handling to prevent contamination. The Administrator/Dietary Manager/maintenance director will review refrigerator/freezer temperature logs and "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."	8/7/12

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F 371	<p>Continued From page 17</p> <p>Observations were made of the walk-in freezer that revealed the internal thermometer specified the freezer's temperature was 28 degrees Fahrenheit. The freezer's contents were also observed and revealed individual cups of ice cream were soft to touch. The Dietary Manager (DM) assisting the facility was present for the observation and confirmed the freezer's internal temperature was too warm.</p> <p>A document titled "Record of Refrigeration Temperatures" for the month of 7/12 was reviewed with the DM and revealed the following freezer Fahrenheit temperatures:</p> <table border="1"> <thead> <tr> <th></th> <th>7:00 a.m.</th> <th>7:30 p.m.</th> </tr> </thead> <tbody> <tr> <td>7/4/12</td> <td>4</td> <td>7</td> </tr> <tr> <td>7/5/12</td> <td>6</td> <td>8</td> </tr> <tr> <td>7/6/12</td> <td>4</td> <td>6</td> </tr> <tr> <td>7/7/12</td> <td>10</td> <td>8</td> </tr> <tr> <td>7/8/12</td> <td>9</td> <td>7</td> </tr> </tbody> </table> <p>Further review of the document specified that freezer temperature was required to be less than or equal to 0 degrees Fahrenheit.</p> <p>On 7/9/12 at 10:45 AM the Assistant Dietary Manager (ADM) was interviewed and reported he was trained that the walk-in freezer temperature was to be 0 degrees Fahrenheit and any temperature above 0 degrees Fahrenheit was to be reported to the Maintenance Director. He also stated he was aware the temperature in the walk-in freezer had been above 0 degrees Fahrenheit for a few days. He stated that he had not notified the Maintenance Director but thought the Maintenance Director was aware and had ordered and part to repair the unit.</p> <p>On 7/9/12 at 10:55 AM the Maintenance Director was interviewed and reported the walk-in freezer was serviced on 6/25/12 and a part had been</p>		7:00 a.m.	7:30 p.m.	7/4/12	4	7	7/5/12	6	8	7/6/12	4	6	7/7/12	10	8	7/8/12	9	7	F 371	<p>sanitizer logs daily to assure temperatures and sanitizer is within normal range. Documentation to support correction for abnormal ranges will be reviewed by the Dietary manager/Administrator/Maintenance director daily ongoing. DON/ADON/RN supervisor/Dietary manager will observe meal tray pass daily x 4 weeks then weekly ongoing to assure trays are handled and stored properly to avoid contamination of trays. The DM began in service education for the dietary staff on 7/9/12 regarding "Monitoring refrigerator/freezer temperatures and testing sanitizer in 3 compartment sink prior to use. Recommended temperature ranges and sanitizer range and procedure for correcting abnormal readings." The Staff development coordinator (SDC) began in service education on 7/16/12 for nursing staff regarding meal tray storage and handling to prevent contamination. The Administrator/Dietary manager will identify any trends or patterns identified during reviews and observations and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified</p> <p>" 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."</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/20
FORM APPROVE
OMB NO. 0938-036

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 07/12/2012
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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 371	<p>Continued From page 18</p> <p>ordered. He confirmed there had been concerns with the unit not keeping temperature at 0 degrees Fahrenheit but that it was likely from staff not closing the door to the unit. He stated that he routinely checked the temperature of the unit and had not noticed concerns. He was not aware the unit was 28 degrees Fahrenheit.</p> <p>2. On 7/11/12 at 11:40 AM the lunch meal service was observed. Prior to the start of the tray line the kitchen's three (3) compartment sink used to clean and sanitize dishware was observed in use. The Assistant Dietary Manager (ADM) was interviewed at this time and reported he was responsible for the setup of the three (3) compartment sink. He reported that he had already completed one load of dishware including utensils and had two other loads to complete. He added he changed the water and chemical concentration out between uses. The ADM tested the chemical concentration of the sanitizer compartment that revealed there was no chemical sanitizer in the water used to wash dishware. The ADM was interviewed at this time and reported he did not utilize a log to record and monitor the chemical concentration of the three (3) compartment sink. He stated he thought he had checked the chemical concentration for the first load of dishware and it was within acceptable limits of 200ppm (parts per million) but that he needed to re-wash and sanitize the utensils to be sure. On 7/11/12 at 12:00 PM the lunch meal tray line was started and the ADM was observed using the serving utensils identified as needing to be re-sanitized for the lunch meal. The ADM was interviewed and stated he forgot to re-sanitize them.</p> <p>3. On 07/09/12 at 1:00 PM an observation revealed nursing assistants (NA) passing lunch trays to residents on the 200 Hall. A subsequent observation at 2:00 PM revealed Resident #8 still</p>	F 371	<p>"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."</p>	

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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 07/12/2012
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 371	Continued From page 19 had not received his lunch tray. During an interview on 07/09/12 at 2:00 PM Licensed Nurse (LN) #2 indicated Resident #8 had not received his lunch tray and asked NA # 3 to get his lunch tray. On 07/09/12 at 2:05 PM, NA #3 was observed removing Resident #8's lunch tray from the back of the meal delivery cart. The observation also revealed Resident #8's tray was located on a shelf behind a dirty tray. Dirty trays were also noted to be on the shelf above and below Resident #8's tray. The observation further revealed NA # delivered the lunch tray to Resident #8's room and set the tray up on his over bed table. An interview was conducted on 07/09/12 at 2:10 PM with NA #3. NA #3 acknowledged she removed and served Resident #8's lunch tray from the cart containing dirty trays. NA #3 further revealed Resident #8's lunch tray should not have been on the cart with dirty trays and was uncertain why Resident #8's lunch remained on the cart. On 07/12/12 at 3:10 PM an interview with the Director of Nursing (DON) revealed dirty trays should not be placed on the tray cart until all of the meals have been distributed to residents. The DON further indicated the NA should not have given Resident #8 the lunch tray which was left on the cart, but obtained a fresh lunch tray instead.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	"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."		

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F 431	<p>Continued From page 20</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to removed two (2) expired vials of Tuberculin Purified Protein Derivative (PPD) from one (1) of one (1) medication storage refrigerator.</p> <p>The findings are: Review of the manufacturer's recommendation for storage of opened vials of Tuberculin PPD</p>	F 431	<p>F 431</p> <p>Corrective action has been accomplished for the alleged deficient practice in regards to expired Tuberculin Purified Protein derivative (PPD) medications found in the medication storage refrigerator. All medications identified as expired were discarded on 7/12/12 according to policy. Residents with orders for medication have the potential to be affected by the alleged deficient practice. SDC provided in service education for licensed nurses beginning 7/16/12 regarding "Policy and Procedure: Dating, labeling and storage of medications and expiration dates for medications once opened." DON/ADON/SDC/RN supervisor will conduct daily audits of medication carts to assure medications are properly labeled, stored and discarded according to policy and procedure. Discrepancies identified will be corrected and reviewed in QAA weekly x 4 weeks then monthly. Monitors put into place to ensure the alleged deficient practice does not recur include: SDC provided in service education for licensed nurses beginning 7/16/12 regarding "Policy and Procedure: Dating, labeling and storage of medications and expiration dates for medications once opened." DON/SDC/RN supervisor will conduct daily audits of medication carts to assure medications are properly labeled, stored</p> <p>"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."</p>	8/7/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 431	<p>Continued From page 21</p> <p>revealed when opened and in use for thirty (30) days should be discarded.</p> <p>Review of a facility policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" with a revision date of 08/09/2011 revealed the following; "once any medication or biological package is opened, facility should follow manufacturer/supplier guide lines with respect to expiration dates for opened medications."</p> <p>On 07/12/12 at 2:40 PM, the medication refrigerator located in the medication storage room was observed to contain two (2) opened vials of Tuberculin PPD. One vial had an open date of 06/04/12 and the other vial had an open date of 06/05/12. Both vials were approximately half full and in the active stock of medications for resident use.</p> <p>An interview with the Director of Nursing (DON) on 07/12/12 at 3:00 PM revealed once opened, vials of PPD are good for thirty days. The DON indicated the Assistant Director of Nursing (ADON) or DON were responsible for checking the expiration dates of medications located in the medication storage room and the medication refrigerator. The DON further revealed she checked the medication refrigerator on 07/09/12 and could not explain why the two vials of expired PPD had not been discarded.</p>	F 431	<p>and discarded according to policy and procedure. Discrepancies identified will be corrected and reviewed in QAA weekly x 4 weeks then monthly.</p> <p>DON/SDC will identify any trends or patterns identified during audits and bring to weekly QAA x 4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified.</p> <p>"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."</p>	