PRINTED 12/12/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB\_NO\_0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP/EJER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AN OF CORRECTION COMPLETED A BUILDING B. WING \_ 345265 11/29/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH BRIAN CENTER HEALTH & REHABIYA YANCEYVILLE, NC 27379 (X4) 1D **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **OFFICIENCY)** F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281 12/27/12 SS=D PROFESSIONAL STANDARDS The services provided or arranged by the facility F281 must meet professional standards of quality. The Physician's order for Klor-Con for Resident #57 was clarified on This REQUIREMENT is not met as evidenced 11/29/2012 for 8 mEq to be given daily and corrected on the Based on observations, medical record review current month's Medication and staff interviews the facility failed to transcribe Administration Record. . an order correctly for the medication Klor Con. A medication transcription order error was found The 3/23/12 Klor-Con order containing during medication pass for one of twelve sampled 10 mEq in the "note section" has been residents. Resident # 57. deleted from the Physician's Monthly The findings include: Order Sheet. Resident #57 was admitted to the facility on 8/20/10 with diagnoses including Congestive All residents have the potential to be Heart Failure and Hypertension. effected by the same alleged deficient practice. Review of the medical record for Resident #57 A review of each resident's revealed an initial physician's order dated Physician's Monthly Order Sheet and 3/23/12 was to administer 8 mEq of Kior Con Medication Administration Record (potassium supplement) every day. is to be completed, by administrative nurses by [12/27/12] to ensure accurate Review of Resident #57 's physician 's orders for transcription of medication orders. the month of November 2012 revealed an order

Review of Resident #57's physician's orders for the month of November 2012 revealed an order for Klor Con (a potassium supplement). The current order instructed 8 mEq of potassium to be administered daily. The added instructions under the order stated "give 10 mEq total dosage by mouth daily at 9:00 AM."

Observations on 11/29/12 at 8:49 AM during medication pass for Resident #57 revealed nurse #1 read the Medication Administration Record (MAR) to prepare the medications for

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

Monthly orders.

Systemic measures to ensure the same

include: the Director of Nursing and

medication order transcription and the

facility's process for recapitulation of

Assistant Director of Nursing will re-educate current licensed nurses on

alleged deficient practice does not recur

TITLE

(X6) DATE

Any deficiency statement ending with an esterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that oth regular a 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 participation.

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

PRINTED 12/12/2017 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIERCHA IDENTIFICATION NUMBER.	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345265	B. WNG		11/29/2012		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABIYA			STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANGEYVILLE, NG 27379				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			COMPLETION DATE	
F 281	administration. After administration instruct dose of the potassium administration record administer. Observat package revealed the was 8 milli-Equivalent on the medication package was 8 mEq. administration record to receive 8 mEq and potassium was not adwas obtained.  The monthly orders for September and Octob transcription error was orders had 8 mEq and medication administration administration record to receive 8 mEq and potassium was not adwas obtained.  The monthly orders for September and Octob transcription error was orders had 8 mEq and medication administration administration administration administration administration for huse #3. Due explained Resident #5 dated 3/23/12 for Klor daily. Nurse #1 explained resident in specified the current of the new monthly order were reviewed. New of the new monthly order were reviewed.	reviewing the Klor Con tions, she questioned the h. The medication had two different doses to ion of the medication dose sent by pharmacy s (mEq). The instructions skage were for 8 mEq to be see in the medication The medication The medication specified Resident #57 was 10 mEq doses. The iministered until clarification or the months of August, her were reviewed once the se identified. The monthly if 10 mEq on for the tion records.  e #1 was conducted on Nurse #1 had clarified the uring the interview nurse #1 io7's original order was Con 8 mEq to be given ined the facility's process monthly orders and orders were compared with res. Any telephone orders orders were then the nonth's MARs. Nurse #1	F 281	The facility's current Health Information Coordinator, response for data entry, will receive one re-education from facility's fie support Pharmacist regarding data entry onto Monthly Physic Order Sheet. Re-education to ibut not limited to, when entering to delete current order then entrorder verses modifying current.  The Director of Nursing and/or designee will validate accurate transcription of new or clarified medication orders to the current month's Medication Administr. Record daily x 2 weeks and a nor fill medication orders times at their random samples, minimum monthly x 3. Results of the audicative findings will be corrected.	on one Id cian's include, ng orders er new order.  d ation ninimum 2 weeks n of 10 lits will	12/27/12	

PRINTED: 12/12/2012 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/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING 345265 11/29/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH **BRIAN CENTER HEALTH & REHABIYA** YANCEYVILLE, NC 27379 (X4) (D PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (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) F 281 Continued From page 2 F 281 on 11/29/12. Results of all audits will be reported to Interview with administrative staff #2 on 11/29/12 at 1:30 PM revealed the 10 mEq was under the the Quality Assessment Performance medication order. That was a "note section" Improvement Committee the nurse can type in for the medication monthly x 3 to identify any administration record. It was explained the patterns/trends. The medical record staff typed the orders into the Quality Assessment Performance medication administration record each month. Improvement Committee will evaluate The nurses did monthly order checks at the end the effectiveness of the plan based on of the month using the current orders with the trends identified. The Committee will next month's orders. The dose had been 10 develop and implement, additional mEq and was changed to 8 mEq on 3/23/12. The interventions as needed to ensure 10 mEq was not deleted from the medication continued compliance. administration record after the dose change.

PARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **YTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY LAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED . A. BUILDING 01 - MAIN BUILDING 01 B. WING \_ 345265 12/21/2012 OF PROVIDER OR SUPPLIER 0 4 2013 STREET ADDRESS, CITY, STATE, ZIP CODE FEB 1086 MAIN STREET NORTH AN CENTER HEALTH & REHAB/YA YANCEYVILLE, NC 27379 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL FIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) **INITIAL COMMENTS** K 000 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 018 The door in the men's 12/21/12 locker room was repaired to Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or ensure it latched properly hazardous areas are substantial doors, such as when closed. those constructed of 1% inch solid-bonded core wood, or capable of resisting fire for at least 20 All doors throughout the minutes. Doors in sprinklered buildings are only facility were inspected by required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors the facility maintenance are provided with a means suitable for keeping staff to ensure they closed the door closed. Dutch doors meeting 19.3.6.3.6 and latched properly. are permitted. 19.3.6.3 2/5/13 All doors will be inspected Roller latches are prohibited by CMS regulations. in all health care facilities. monthly to ensure they close and latch properly. The results of these 2/5/13 findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next annual inspection. This STANDARD is not met as evidenced by: A. Based on observation on 12/21/2012 the door Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE y statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that irds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued dpation.

17(02-99) Previous Versions Obsolete

Event ID: V89221

Facility ID: 923000

If continuation sheet Page 1 of 2

PKIN I ED: 01/02/2013

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **EMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA COMPLETED LAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 - MAIN BUILDING 01 B. WING 345265 12/21/2012 STREET ADDRESS, CITY, STATE, ZIP CODE OF PROVIDER OR SUPPLIER 1086 MAIN STREET NORTH AN CENTER HEALTH & REHABIYA YANCEYVILLE, NC 27379 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX FΙΧ TAG DEFICIENCY) Continued From page 1 K 018 to the men's locker room failed to latch when closed. 42 CFR 483.70 (a) 12/21/12 NFPA 101 LIFE SAFETY CODE STANDARD K 050 )50 The staff member involved ≔D was in-serviced on the Fire drills are held at unexpected times under correct facility Fire varying conditions, at least quarterly on each shift. Response Procedures The staff is familiar with procedures and is aware that drills are part of established routine. utilizing visual aids and the Responsibility for planning and conducting drills is R.A.C.E. system. assigned only to competent persons who are 2/5/13 qualified to exercise leadership. Where drills are All Staff in all departments conducted between 9 PM and 6 AM a coded will be trained on Fire Drill announcement may be used instead of audible 19.7.1.2 alarms. Response Procedures using the R.A.C.E. response system as well as using visual aids, lectures, and This STANDARD is not met as evidenced by: practical application doing A. Based on observation on 12/21/2012 the staff interviewed did not know the fire drill procedure. Fire Drills. 42 CFR 483,70 (a) Fire Drills will be performed on all Shifts monthly for 3 months to ensure everyone knows the proper Fire Response Procedures. 2/5/13 The results of these findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next annual inspection. If continuation sheet Page 2 of 2 Fadlity ID: 923000 2567(02-99) Previous Versions Obsolete Event ID: V89221

PARTMENT OF HEALTH AND HUMAN SERVICES

**ITERS FOR MEDICARE & MEDICAID SERVICES** 

PRINTED: 01/02/2013

OMB NO. 0938-0391

FORM APPROVED

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

This STANDARD is not met as evidenced by:

A. Based on observation on 12/21/2012 the door

TITLE

annual inspection.

The results of these

findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next

(X6) DATE

ficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ig 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 tlowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued in participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES SENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

/ENIC	KS FUR MEDICARI	E & MEDIÇAID SERVICES				OMD IN	<del>, บยงด-บงย</del>	
ATEMENT OF DEFICIENCIES B PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
	345265		B. WING			12/21/2012		
	PROVIDER OR SUPPLIER CENTER HEALTH & R	EHAB/YA		1	REET ADDRESS, CITY, STATE, ZIP CODE 086 MAIN STREET NORTH ANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
•	closed. 42 CFR 483.70 (a)	room failed to latch when		)18		,	1	
K 050 SS=D	Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for plassigned only to conqualified to exercise conducted between announcement may alarms. 19.7.1.2  This STANDARD is A. Based on observer.	at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. Ianning and conducting drills is mpetent persons who are leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible on the procedure of the staff know the fire drill procedure.	K	050	The staff member involved was in-serviced on the correct facility Fire Response Procedures utilizing visual aids and the R.A.C.E. system.  All Staff in all departments will be trained on Fire Drill Response Procedures using the R.A.C.E. response system as well as using visual aids, lectures, and practical application doing Fire Drills.	·	2/5/13	
	42 OTT 10017 (a)			1111111	Fire Drills will be performed on all Shifts monthly for 3 months to ensure everyone knows the proper Fire Response Procedures.  The results of these		2/5/13	
					findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next annual inspection.		•	

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

PRINTED: 02/11/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHABIYA    STREET ADDRESS, CITY, STATE, ZIP CODE 1988 MAIN STREET NORTH YANGEVYLLE, DR. C 27379    PARTIX   SUMMARY STATEMENT OF DEFICIENCIES   PARTIX   PROVIDERS PLAN OF CORRECTION   PARTIX   PART	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHABI/YA  (X4) ID PREED (EACH OPPOPER NOT HE PREGNICE OF FULL TAX OF COLOR OF THE PROVIDER OF THE PROVIDE	MIDI DE OF SOURSON			A. BUILDING 02 - BLDG 02 OF 02  B. WING		·-	40/04/0040	
BRIAN CENTER HEALTH & REHABIVA    1088 MAIN STREET NORTH   YANCEYVILLE, NC 27379			345265	J. VVII		. [ 121		1/2012
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000 INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a), using the Existing Health Care section of the LSC and its referenced publications. This building is Type V 111 construction, one story, with a complete automatic sprinkler system.  The deficiencies determined during the survey are as follows Based on observation and staff interview there were no LSC deficiencies noted.	1		ЕНАВ/ҮА		10	86 MAIN STREET NORTH ANCEYVILLE, NC 27379		
This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CPR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V 111 construction, one story, with a complete automatic sprinkler system.  The deficiencies determined during the survey are as follows Based on observation and staff interview there were no LSC deficiencies noted.	PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SI		TOULD BE COMPLET		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		This Life Safety Coconducted as per Tat 42 CFR 483.70(a Care section of the publications. This beconstruction, one sautomatic sprinkler.  The deficiencies deare as follows Base	ode(LSC) survey was The Code of Federal Register a); using the Existing Health LSC and its referenced building is Type V 111 tory, with a complete system. etermined during the survey and on observation and staff			DEFICIENCY)		
	ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

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.