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

PRINTED 12/12/2012
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 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 observations, medical record review and staff interviews the facility failed to transcribe an order correctly for the medication Klor Con. A medication transcription order error was found during medication pass for one of twelve sampled residents. Resident # 57. The findings include: Resident #57 was admitted to the facility on 8/20/10 with diagnoses including Congestive Heart Failure and Hypertension. Review of the medical record for Resident #57 revealed an initial physician ' s order dated 3/23/12 was to administer 8 mEq of Klor Con (potassium supplement) every day. 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	F 281	F281 The Physician's order for Klor-Con for Resident #57 was clarified on 11/29/2012 for 8 mEq to be given daily and corrected on the current month's Medication Administration Record. . The 3/23/12 Klor-Con order containing 10 mEq in the "note section" has been deleted from the Physician's Monthly Order Sheet. All residents have the potential to be effected by the same alleged deficient practice. A review of each resident's Physician's Monthly Order Sheet and Medication Administration Record is to be completed, by administrative nurses by [12/27/12] to ensure accurate transcription of medication orders. Systemic measures to ensure the same alleged deficient practice does not recur include: the Director of Nursing and Assistant Director of Nursing will re-educate current licensed nurses on medication order transcription and the facility's process for recapitulation of Monthly orders.	12/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 281	Continued From page 1 administration. After reviewing the Klor Con administration instructions, she questioned the dose of the potassium. The medication administration record had two different doses to administer. Observation of the medication package revealed the dose sent by pharmacy was 8 milli-Equivalents (mEq). The instructions on the medication package were for 8 mEq to be administered. The dose in the medication package was 8 mEq. The medication administration record specified Resident #57 was to receive 8 mEq and 10 mEq doses. The potassium was not administered until clarification was obtained. The monthly orders for the months of August, September and October were reviewed once the transcription error was identified. The monthly orders had 8 mEq and 10 mEq on for the medication administration records. An interview with nurse #1 was conducted on 11/29/12 at 10:00 AM. Nurse #1 had clarified the order for nurse #3. During the interview nurse #1 explained Resident #57 ' s original order was dated 3/23/12 for Klor Con 8 mEq to be given daily. Nurse #1 explained the facility ' s process for checking resident monthly orders and specified the current orders were compared with the new monthly orders. Any telephone orders were reviewed. New orders were then the updated on the next month ' s MARs. Nurse # 1 stated she had completed Resident #57 ' s November 2012 monthly medication checks and did not identify that the resident had an order for Klor Con that mistakenly contained two different doses. Nurse #1 stated she had "missed it. " She would clarify the order and made corrections	F 281	The facility's current Health Information Coordinator, responsible for data entry, will receive one on one re-education from facility's field support Pharmacist regarding data entry onto Monthly Physician's Order Sheet. Re-education to include, but not limited to, when entering orders to delete current order then enter new order verses modifying current order. The Director of Nursing and/or designee will validate accurate transcription of new or clarified medication orders to the current month's Medication Administration Record daily x 2 weeks and a minimum of 10 medication orders times 2 weeks then random samples, minimum of 10 monthly x 3. Results of the audits will be reviewed weekly during the Interdisciplinary Team meeting. Negative findings will be corrected if noted.	12/27/12

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F 281	Continued From page 2 on 11/29/12. Interview with administrative staff #2 on 11/29/12 at 1:30 PM revealed the 10 mEq was under the medication order. That was a " note section " the nurse can type in for the medication administration record. It was explained the medical record staff typed the orders into the medication administration record each month. The nurses did monthly order checks at the end of the month using the current orders with the next month ' s orders. The dose had been 10 mEq and was changed to 8 mEq on 3/23/12. The 10 mEq was not deleted from the medication administration record after the dose change.	F 281	Results of all audits will be reported to the Quality Assessment Performance Improvement Committee monthly x 3 to identify any patterns/trends. The Quality Assessment Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified. The Committee will develop and implement, additional interventions as needed to ensure continued compliance.	

EMENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/21/2012

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AN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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ID FIX G	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
000	INITIAL COMMENTS 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:	K 000		
18 D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 12/21/2012 the door	K 018	The door in the men's locker room was repaired to ensure it latched properly when closed. All doors throughout the facility were inspected by the facility maintenance staff to ensure they closed and latched properly. All doors will be inspected monthly to ensure they close and latch properly. The results of these findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next annual inspection.	12/21/12 1/10/13 2/5/13 2/5/13

Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Cordelia Jones 1/11/13

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018	Continued From page 1 to the men's locker room failed to latch when closed. 42 CFR 483.70 (a)	K 018		
050 =D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 12/21/2012 the staff interviewed did not know the fire drill procedure. 42 CFR 483.70 (a)	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. 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 findings will be reviewed with the Safety Team Committee for 3 months then quarterly until next annual inspection.	12/21/12 2/5/13 2/5/13 2/5/13

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	345265	A. BUILDING 02 - BLDG 02 OF 02 B. WING _____	12/21/2012

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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.	K 000		

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