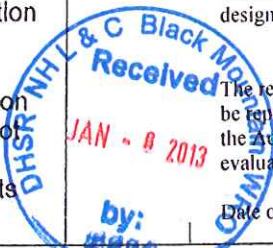


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/05/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/CH			STREET ADDRESS, CITY, STATE, ZIP CODE 5939 REDDMAN ROAD CHARLOTTE, NC 28212	
(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 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to post a notice of the survey results availability.</p> <p>The findings included:</p> <p>Interview with Resident #64, resident council president, on 12/05/13 at 9:26 AM, revealed the location of the facility's survey result for resident review was not known.</p> <p>Observation on 12/05/13 at 9:26 AM revealed a binder labeled "facility survey information" on a table next to the receptionist desk in the front lobby. There was no posted notice in the lobby or on the nursing units which indicated the location of the survey information binder.</p> <p>Interview with the Director of Nursing (DON) on 12/05/13 at 9:31 AM revealed a notice was not posted. The DON reported she would immediately post a notice of the survey results availability.</p>	F 167	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p><u>F167</u> <u>Criteria 1</u></p> <p>The Resident Council President was re-educated by the Director of Nursing on 12/05/2013, regarding the location of the facility's survey result. A sign was posted, by the Director of Nursing, in the lobby indicating the location of the binder on 12/5/13. <u>Criteria 2</u></p> <p>All resident have the potential to be affected by this alleged deficient practice <u>Criteria 3</u></p> <p>The Administrator or designee will re-educate the Department Managers on the requirements of F167 for posting the facility's survey results for review by residents, visitors and staff. This re-education will be completed by 1-2-14. The Administrator or designee will observe to verify both the signage and binder is in place weekly for 4 weeks then monthly for 2 months. Opportunities identified as a result of these observations and reviews will be corrected by the Administrator or designee. <u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Administrator or Designee, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: 1-3-14

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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, direct care staff failed to engage residents in conversation while providing care for 4 of 25 sampled residents (Resident #20, #8, #29, #42)</p> <p>The findings included:</p> <p>1. During observations of lunch on 12/02/13 at 1:03 PM Nurse Aide (NA) #1 was observed delivering a tray to Resident #20. NA #1 knocked on the resident's door and dictated resident care information into her headset while walking into the room. NA #1 placed the lunch tray on Resident #20's over bed table and began setting up the tray while she continued to speak into the head set. NA #1 paused briefly and asked Resident #20 a question then resumed dictating resident care information into her headset until she had completed tray set up for Resident #20.</p> <p>An interview was conducted with Resident #20 on 12/05/13 at 8:50 AM. During the interview Resident #20 stated the NAs talked into their headsets all the time while providing care and she did not like this practice because she could not talk to the NAs.</p> <p>During an interview on 12/05/13 at 12:10 PM the</p>	F 241	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F241</p> <p><u>Criteria 1</u></p> <p>NAs # 1, 2 and 3 were re-educated by the Director of Nursing on 12/6/13 regarding maintaining dignity while providing care to residents including meal service and methods for utilizing the headset to document resident care information while observing privacy and dignity</p> <p><u>Criteria 2</u></p> <p>All resident have the potential to be affected by this alleged deficient practice</p>	

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F 241	<p>Continued From page 2</p> <p>Staff Development Coordinator (SDC) stated the NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays.</p> <p>An interview with NA #1 on 12/05/13 at 1:00 PM revealed she recalled documenting resident care information into her head set while delivering lunch trays to residents on 12/02/13. NA #1 further stated she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents.</p> <p>During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents.</p> <p>An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care.</p> <p>2. a. Observations of lunch on 12/02/13 at 12:57 PM revealed NA #1 delivered a tray to Resident #8 in her room. NA #1 dictated resident care information into her headset the entire time she set up Resident #8's tray and did not interact with the resident. Review of Resident #8's quarterly Minimum Data Set (MDS) dated 08/14/13 revealed she had severely impaired cognition and could not be interviewed.</p> <p>During an interview on 12/05/13 at 12:10 PM the</p>	F 241	<p><u>Criteria 3</u></p> <p>The Staff Development Coordinator or designee will re-educate all Resident Care Specialists (RCS) regarding maintaining dignity while providing resident care including meal service and methods for utilizing the Accu-Nurse headset to document resident care information while observing privacy and dignity. This re-education will be completed by 1-2-14. The Staff Development Coordinator or designee will randomly observe 10 RCSs weekly for 4 weeks and monthly for 2 months, to verify maintenance of dignity and privacy while providing and documenting resident care. Opportunities will be corrected as identified.</p> <p><u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>		

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F 241	<p>Continued From page 3</p> <p>Staff Development Coordinator (SDC) stated the NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays.</p> <p>An interview with NA #1 on 12/05/13 at 1:00 PM revealed she recalled documenting resident care information into her head set while delivering lunch trays to residents on 12/02/13. NA #1 further stated she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents.</p> <p>During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents.</p> <p>An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care.</p> <p>b. Observations of lunch on 12/02/13 at 1:00 PM revealed NA #1 delivered a tray to Resident #29 in her room. NA #1 dictated resident care information into her headset the entire time she set up Resident #29's tray and did not interact with the resident. Review of Resident #29's annual Minimum Data Set (MDS) dated 10/01/13 revealed she had severely impaired cognition and could not be interviewed.</p> <p>During an interview on 12/05/13 at 12:10 PM the</p>	F 241			

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F 241	<p>Continued From page 4</p> <p>Staff Development Coordinator (SDC) stated the NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays.</p> <p>An interview with NA #1 on 12/05/13 at 1:00 PM revealed she recalled documenting resident care information into her head set while delivering lunch trays to residents on 12/02/13. NA #1 further stated she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents.</p> <p>During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents.</p> <p>An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care.</p> <p>c. Observations of lunch on 12/02/13 at 1:06 PM revealed NA #1 delivered a tray to Resident #42 in his room. NA #1 greeted Resident #42 by name as she entered the room and then dictated resident care information into her headset the entire time she set up Resident #42's tray. NA #1 was not observed interacting with the resident. Review of Resident #42's quarterly Minimum Data Set (MDS) dated 10/03/13 revealed he had short and long-term memory loss and could not be interviewed.</p>	F 241			

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F 241	Continued From page 5 During an interview on 12/05/13 at 12:10 PM the Staff Development Coordinator (SDC) stated the NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays. An interview with NA #1 on 12/05/13 at 1:00 PM revealed she recalled documenting resident care information into her head set while delivering lunch trays to residents on 12/02/13. NA #1 further stated she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents. During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents. An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care. d. Observations of lunch on 12/03/13 at 12:20 PM revealed NA # 3 delivered a tray to Resident #29 in her room. NA #3 dictated resident care information into her headset the entire time she set up Resident #29's tray and did not interact with the resident. Review of Resident # 29's annual Minimum Data Set (MDS) dated 10/01/13 revealed she had severely impaired cognition and could not be interviewed.	F 241		

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F 241	Continued From page 6 During an interview on 12/05/13 at 12:10 PM the Staff Development Coordinator (SDC) stated the NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays. During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents. An interview with NA #3 on 12/05/13 at 2:50 PM revealed she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents. An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care. e. Observations of lunch on 12/04/13 at 12:59 PM revealed NA #1 delivered a tray to Resident #8 in her room. NA #1 dictated resident care information into her headset the entire time she set up Resident #8's tray and did not interact with the resident. Review of Resident #8's quarterly Minimum Data Set (MDS) dated 08/14/13 revealed she had severely impaired cognition and could not be interviewed. During an interview on 12/05/13 at 12:10 PM the Staff Development Coordinator (SDC) stated the	F 241		

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F 241	Continued From page 7 NAs were instructed during the headset training they were not supposed to document resident care information into their headsets while providing care to residents including when they were setting up meal trays. An interview with NA #1 on 12/05/13 at 1:00 PM revealed she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents. During an interview on 12/05/13 at 2:45 PM NA #2 stated NAs were instructed they could not document resident care information into their headsets while they were providing care to residents. An interview with NA #3 on 12/05/13 at 2:50 PM revealed she was trained to document resident care information into her headset in the hallway or common areas but not while providing care to the residents. An interview with the Director of Nursing on 12/05/13 at 3:00 PM revealed she expected the NAs to interact with residents while providing care and not document resident care information into their headsets while providing care.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242		

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F 242	<p>Continued From page 8 are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to provide a choice in the frequency and type of baths for 4 of 5 sampled residents (Residents #64, #95, #115, and #142).</p> <p>The findings included:</p> <p>1. Review of Resident #64's annual Minimum Data Set dated 08/17/13 revealed an assessment of intact cognition with the choice of type of bath listed as very important.</p> <p>Interview with Resident #64 on 12/02/13 at 4:17 PM revealed a preference for tub baths. Resident #64 explained a "long soak in the tub" would be her choice. Resident #95 reported she did not think a tub bath could be offered at the facility.</p> <p>Interview with Nurse Aide (NA) #5 on 12/04/13 at 2:55 PM revealed Resident #64 received twice weekly showers. NA #5 explained showers were assigned by room number and did not offer a choice of bath type to Resident #64.</p> <p>During an interview on 12/05/13 at 2:26 PM Nurse #3 (unit manager) stated choices for type of bath or shower and frequency of baths or showers were not determined during the admission process. Nurse #3 indicated if a resident or family member informed staff of a specific preference during the admission process or at any time they would accommodate the</p>	F 242	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F242</p> <p><u>Criteria 1</u></p> <p>Residents #64, 95, 115 and 142 were assessed by the Unit Manager for preferences related to activities of daily living related to bathing and preferences implemented by 1/2/14</p> <p><u>Criteria 2</u></p> <p>All resident have the potential to be affected by this alleged deficient practice. The Unit Manager completed an audit of all residents by 1/2/14 to verify their preferences related to bathing.</p>	

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F 242	<p>Continued From page 9 request.</p> <p>An interview with the Activity Director on 12/05/13 at 2:10 PM revealed she completed the MDS questions with residents regarding preferences for customary routine activities for all admission and annual MDS assessments. The Activity Director indicated residents were asked how important it was for them to choose between a tub bath, shower, bed bath, or sponge bath. The interview further revealed choices regarding frequency and type of bath or shower were not included in the interview.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/05/13 at 3:00 PM. During the interview the DON stated residents and/or family members were informed of the residents two assigned shower days and shift during the admission process. The interview further revealed the shower schedule was determined by room number and bed number. The DON recalled when residents requested showers to be changed to a different shift these requests were accommodated. The DON further stated the facility did not determine residents' preference for type of bath or frequency of baths or showers during the admission process or at any other time.</p> <p>2. Review of Resident #95's annual Minimum Data Set dated 02/10/13 revealed an assessment of poor short term and long term memory with the choice of bath type listed as very important.</p> <p>Interview on 12/03/13 at 12:14 PM with Resident # 95's family member revealed Resident # 95 preferred tub baths before admission to the facility.</p>	F 242	<p><u>Criteria 3</u></p> <p>The Director of Nursing has developed an additional interview tool for use during the admission process to identify resident preferences related to bathing schedules. Licensed Nursing Staff will be educated by the Staff Development Coordinator or Designee on completion of the interview regarding bathing preferences upon admission. Nursing Staff has been re-educated by the Staff Development Coordinator or Designee on adhering to resident preferences regarding bathing schedules and communicating a resident's request for change in bathing schedules to the Director of Nursing or Unit Manager. The education will be completed by 1/2/14. The Unit Manager or Designee will randomly interview 5 residents weekly for 4 weeks and then monthly for 2 months to verify bathing preferences are being followed. Opportunities will be corrected as identified.</p>	

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F 242	Continued From page 10 Interview with Nurse Aide (NA) #5 on 12/04/13 at 2:58 PM revealed Resident #95 received twice weekly showers. During an interview on 12/05/13 at 2:26 PM Nurse #3 (unit manager) stated choices for type of bath or shower and frequency of baths or showers were not determined during the admission process. Nurse #3 indicated if a resident or family member informed staff of a specific preference during the admission process or at any time they would accommodate the request. An interview with the Activity Director on 12/05/13 at 2:10 PM revealed she completed the MDS questions with residents regarding preferences for customary routine activities for all admission and annual MDS assessments. The Activity Director indicated residents were asked how important it was for them to choose between a tub bath, shower, bed bath, or sponge bath. The interview further revealed choices regarding frequency and type of bath or shower were not included in the interview. An interview was conducted with the Director of Nursing (DON) on 12/05/13 at 3:00 PM. During the interview the DON stated residents and/or family members were informed of the residents two assigned shower days and shift during the admission process. The interview further revealed the shower schedule was determined by room number and bed number. The DON recalled when residents requested showers to be changed to a different shift these requests were accommodated. The DON further stated the facility did not determine residents' preference for	F 242	<u>Criteria 4</u> The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated. Date of Compliance: 1/2/14	

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F 242	<p>Continued From page 11</p> <p>type of bath or frequency of baths or showers during the admission process or at any other time.</p> <p>3. Resident #115 was admitted on 05/23/13 with diagnoses including history of cerebrovascular accident (CVA) and muscle weakness. An admission Minimum Data Set (MDS) dated 05/30/13 revealed Resident #115 was cognitively intact and required extensive assistance for personal hygiene and bathing.</p> <p>During an interview on 12/03/13 at 10:23 AM Resident #115 stated she did not have a choice regarding how many times a week she received a shower. Resident #115 further stated she received a showers every Monday and Thursday morning but would prefer to have a shower every day. The interview further revealed Resident #115 had requested more than two showers a week and was told she could only have two a week.</p> <p>An interview with Nurse Aide (NA) #4 on 12/04/13 at 10:40 AM revealed residents were scheduled two showers a week and the NAs were alerted through their headset which residents on their assignment needed a shower on their shift for that particular day.</p> <p>During an interview on 12/05/13 at 2:26 PM Nurse #3 (unit manager) stated choices for type of bath or shower and frequency of baths or showers were not determined during the admission process. Nurse #3 indicated if a resident or family member informed staff of a specific preference during the admission process or at any time they would accommodate the request.</p>	F 242		

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F 242	Continued From page 12 An interview with the Activity Director on 12/05/13 at 2:10 PM revealed she completed the MDS questions with residents regarding preferences for customary routine activities for all admission and annual MDS assessments. The Activity Director indicated residents were asked how important it was for them to choose between a tub bath, shower, bed bath, or sponge bath. The interview further revealed choices regarding frequency and type of bath or shower were not included in the interview. An interview was conducted with the Director of Nursing (DON) on 12/05/13 at 3:00 PM. During the interview the DON stated residents and/or family members were informed of the residents two assigned shower days and shift during the admission process. The interview further revealed the shower schedule was determined by room number and bed number. The DON recalled when residents requested showers to be changed to a different shift these requests were accommodated. The DON further stated the facility did not determine residents' preference for type of bath or frequency of baths or showers during the admission process or at any other time. 4. Resident #142 was admitted on 11/19/13 with diagnoses including debility, lumbar spinal stenosis, and chronic ischemic heart disease. Review of the medical record revealed Resident #142 was cognitively intact and required extensive assistance with bathing. During an interview on 12/02/13 at 4:45 PM Resident #142 stated she did not have a choice regarding how many times a week she received a	F 242		

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F 242	<p>Continued From page 13</p> <p>shower and was not asked if she would prefer a tub bath. Resident #142 further stated she was told her showers were scheduled for Wednesday and Saturday when she was admitted.</p> <p>An Interview with Nurse Aide (NA) #4 on 12/04/13 at 10:40 AM revealed residents were scheduled two showers a week and the NAs were alerted through their headset which residents on their assignment needed a shower on their shift for that particular day.</p> <p>During an interview on 12/05/13 at 2:26 PM Nurse #3 (unit manager) stated choices for type of bath or shower and frequency of baths or showers were not determined during the admission process. Nurse #3 indicated if a resident or family member informed staff of a specific preference during the admission process or at any time they would accommodate the request.</p> <p>An interview with the Activity Director on 12/05/13 at 2:10 PM revealed she completed the MDS questions with residents regarding preferences for customary routine activities for all admission and annual MDS assessments. The Activity Director indicated residents were asked how important it was for them to choose between a tub bath, shower, bed bath, or sponge bath. The interview further revealed choices regarding frequency and type of bath or shower were not included in the interview.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/05/13 at 3:00 PM. During the interview the DON stated residents and/or family members were informed of the residents two assigned shower days and shift during the</p>	F 242			

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F 242	Continued From page 14 admission process. The interview further revealed the shower schedule was determined by room number and bed number. The DON recalled when residents requested showers to be changed to a different shift these requests were accommodated. The DON further stated the facility did not determine residents' preference for type of bath or frequency of baths or showers during the admission process or at any other time.	F 242	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F309</p> <p><u>Criteria I</u></p> <p>Resident # 118 was immediately assessed and medicated for pain by the Treatment Nurse upon identification of this alleged deficient practice on 12/4/13. A medication variance report was completed and the Physician was notified on 12/4/13 by the Unit Manager</p>	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to administer a pain medication as prescribed before wound care for 1 of 3 sampled residents who received wound care (Resident #118).</p> <p>The findings included:</p> <p>Resident #118 was admitted to the facility on 06/28/13 with diagnoses which included Chronic Obstructive Pulmonary Disease and Congestive Heart Failure.</p> <p>Review of Resident #118's significant change</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>Minimum Data Set dated 09/14/13 revealed an assessment of intact cognition with occasional pain and risk for pressure sores.</p> <p>Review of Resident #118's pressure ulcer record dated 11/14/13 revealed an unstageable area on the upper back and sacrum with daily dressing changes ordered by the wound physician.</p> <p>Review of a physician's order dated 11/18/13 revealed direction to administer Morphine Sulfate 5 milligrams (a narcotic analgesic) 30 to 60 minutes prior to wound care.</p> <p>Review of the wound physician's order dated 11/27/13 revealed direction for daily dressing change to a shear area on the right buttock. The wound physician documented resolution of the pressure wound on the upper sacrum. The wound physician described the right buttock area with undermining and a 28.00 squared centimeter (cm.) surface. The area measured 7.0 cm. by 4.0 cm. by 1.5 cm.</p> <p>Review of the controlled medication record revealed Nurse #2 removed the Morphine Sulfate from the medication cart at 8:00 AM on 12/04/13.</p> <p>Review of the December 2013 Medication Administration Record revealed Nurse #2 initialed the Morphine as administered at a scheduled time of 9:00 AM.</p> <p>Interview with Nurse #5, the wound nurse, on 12/04/13 at 9:01 AM revealed Resident #118 received the pain medication and would receive a dressing change.</p> <p>Observation on 12/04/13 at 9:43 AM revealed</p>	F 309	<p><u>Criteria 2</u></p> <p>Residents with physician's orders to receive pain medication prior to wound care treatments have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee will complete an audit of current medication administration records for residents with physician's orders to receive pain medication prior to wound care to verify administration as ordered by 1/2/14.</p> <p><u>Criteria 3</u></p> <p>. The Staff Development Coordinator or designee will re-educated Licensed Nurses regarding timely administration of physician ordered pain medication prior to providing wound care and the assessment and intervention of pain while providing wound care. This re-education will be completed by 1/2/14.</p>		

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F 309	<p>Continued From page 16</p> <p>Nurse #5 changed Resident #118's dressing. Resident #118 announced "that was really too much pain" at 9:51 AM, when Nurse #6 patted the area with gauze after cleansing with normal saline.</p> <p>Interview with Resident #118 on 12/04/13 at 9:53 AM revealed he received the pain medication before breakfast. Resident #118 explained he "sometimes gets the pain medication exactly right and sometimes it wears off before they do the dressing." Resident # 118 reported the pain medication eased his pain when he received it after breakfast and before the dressing change.</p> <p>Interview with Nurse #2 on 12/04/13 at 10:05 AM revealed Resident #118 received the Morphine Sulfate before breakfast at 8:00 AM. Nurse #2 reported Nurse #6 directed her to administer the medication at that time.</p> <p>Interview with Nurse #5 on 12/04/13 at 10:07 AM revealed he asked Nurse #2 to administer the Morphine Sulfate at 8:00 AM before breakfast. Nurse #5 reported he delayed the treatment change due to the breakfast meal delivery and Resident #118's need for incontinence care. Nurse #5 reported Resident # 118 should receive the Morphine Sulfate 30 to 60 minutes prior to the dressing change. Nurse #5 reported he did not realize the dressing change occurred 105 minutes after the Morphine Sulfate administration instead of 30 to 60 minutes later. Nurse #5 reported he should have assessed Resident #118 for pain prior to the dressing change.</p> <p>Interview with the Director of Nursing on 12/04/13 at 10:26 AM revealed she expected nurses to administer pain medication as ordered and cease</p>	F 309	<p>The Director of Nursing or designee will randomly observe 3 residents receiving wound care, weekly for 4 weekly then monthly for 2 months, to verify accurate administration of pain medication and assessment and intervention of pain during wound care. Opportunities will be corrected as identified.</p> <p><u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>		

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F 309	Continued From page 17	F 309		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide an enteral tube feeding per physician's orders for approximately four hours for 1 of 1 sampled sample resident with a feeding tube (Resident #83).</p> <p>The findings included:</p> <p>Resident #83 was admitted on 08/18/10 with</p>	F 322	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F322</p> <p><u>Criteria 1</u></p> <p>Nurse #3 restarted the enteral feeding for Resident #83 at approximately 12:30pm on 12/4/13. The Physician and the Registered Dietitian were notified immediately with no new orders given on 12/4/13.</p> <p><u>Criteria 2</u></p> <p>Residents receiving a continuous enteral feeding have the potential to be affected by this alleged deficient practice.</p>	

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F 322	<p>Continued From page 18</p> <p>diagnoses including persistent vegetative state, diabetes mellitus type II, PEG tube (gastrostomy feeding tube inserted directly into the stomach), and seizure disorder. A quarterly Minimum Data Set (MDS) dated 10/30/13 revealed Resident #83 had a feeding tube and received 51% or more of her total calories through tube feeding.</p> <p>Review of the medical record revealed a physician's order dated 11/07/13 for Resident #83 to receive Glucerna 1.5 (high calorie/high protein liquid for enteral tube feeding) continuously at a rate of 55 ml (milliliters) per hour.</p> <p>Observations of Resident #83 included the following:</p> <ul style="list-style-type: none"> - On 12/04/13 at 8:45 AM the resident was observed resting quietly in bed with the head of the bed elevated 45 degrees. The display screen on the enteral feeding pump was blank and did not indicate the rate per hour for the continuous tube feeding. Approximately 300 ml remained in enteral feeding container. - On 12/04/13 at 10:46 AM the resident was observed resting quietly in bed with the head of the bed elevated 45 degrees. The display screen on the enteral feeding pump was blank and did not indicate the rate per hour for the continuous tube feeding. Approximately 300 ml remained in enteral feeding container. - On 12/04/13 at 12:21 PM the resident was observed resting quietly in bed with the head of the bed elevated 45 degrees. The display screen on the enteral feeding pump was blank and did not indicate the rate per hour for the continuous tube feeding. Approximately 300 ml remained in enteral feeding container. Nurse aide (NA) #4 had just exited Resident #83's room after providing care. 	F 322	<p><u>Criteria 3</u></p> <p>The Staff Development Coordinator or designee will re-educate Licensed Nursing Staff on the care and maintenance of residents receiving a continuous enteral feeding, to include periodic verification of continuous administration via enteral feeding pump. The re-education will be completed by 1/2/14. The Unit Manager will randomly review up to 3 residents receiving continuous enteral feedings to verify accurate continuous administration via enteral feeding pump, weekly for 4 weeks then monthly for 2 months. Opportunities will be corrected as identified.</p> <p><u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>	

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F 322	<p>Continued From page 19</p> <p>An interview was conducted with Nurse #3 (unit manager) on 12/04/13 at 12:27 PM. During the interview Nurse #3 observed Resident #83's enteral feeding pump and confirmed it was turned off and not running. Nurse #3 turned on the enteral feeding pump at that time and stated nurses were expected to check feeding pumps periodically throughout their shift to ensure they were infusing. The interview further revealed NAs placed enteral feedings on hold while providing care.</p> <p>During an interview on 12/04/13 at 12:50 PM NA #4 stated she did not recall if Resident #83's enteral feeding pump was infusing when she provided care earlier and also noted she did not ever touch the control panel.</p> <p>An interview with Nurse #4 on 12/04/13 at 2:50 PM revealed she was the nurse assigned to Resident #83 for the 7:00 AM to 3:00 PM shift. Nurse #4 stated she had checked Resident #83's tube feeding at approximately 8:15 AM and it was infusing at 55 ml per hour. Nurse #4 further stated it had been a hectic morning and she had not been in to check on Resident # 83's enteral feeding since 8:15 AM and had no idea how or when it had been turned off. The interview further revealed Nurse #4 typically monitored resident's enteral feedings a few times during the shift to ensure it was infusing properly.</p> <p>During an interview on 12/05/13 at 3:39 PM the Director of Nursing (DON) stated nurses were expected to monitor enteral feedings periodically throughout their shift to ensure the tube feeding was infusing properly at the rate prescribed by the physician.</p>	F 322		

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F 325 SS=D	<p>483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a meal to 1 of 3 sampled residents at risk for weight loss (Resident #113).</p> <p>The findings included:</p> <p>Resident #113 was admitted to the facility on 05/11/13 with diagnoses which included dementia.</p> <p>Review of Resident #113's care plan dated 10/02/13 revealed a problem of weight loss. Interventions included provision of diet as ordered and assistance with meals.</p> <p>Review of Resident #113's quarterly Minimum Data Set dated 10/07/13 revealed an assessment of severely impaired cognition. Resident #113 required the extensive assistance of one person with eating.</p>	F 325	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F325</p> <p><u>Criteria 1</u></p> <p>After being prompted, NA#6 assisted resident #113 with 75% consumption of the lunch meal at 1:30pm on 12/2/13.</p> <p><u>Criteria 2</u></p> <p>Residents requiring assistance with meals have the potential to be affected by this alleged deficient practice.</p>	

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F 325	<p>Continued From page 21</p> <p>Review of monthly physician's orders dated 12/02/13 revealed direction to serve Resident #113 a mechanical soft diet with nectar thick liquids, pureed meat and twice daily frozen nutritional treats.</p> <p>Observation on 12/02/13 at 12:25 PM revealed Resident #113 asleep and seated in a wheelchair in the activity room. Resident's lunch tray arrived on the nursing unit in a closed cart at 12:28 PM.</p> <p>Observation on 12/02/13 from 12:28 PM to 1:06 PM revealed nursing staff delivered the lunch meals and assisted residents on the nursing unit. Resident #113's lunch meal remained on the meal cart. Resident #113 remained asleep seated in the wheelchair. Seated next to Resident #113, Resident #138 consumed a lunch meal.</p> <p>Observation on 12/02/13 at 1:06 PM revealed Resident # 113 awakened. Resident #138's remaining food remained on an over the bed table with wheels next to Resident #113.</p> <p>Observation on 12/02/13 at 1: 08 PM revealed Resident #113 pulled the over the bed table in front of him and attempted to take peas from the plate without success. Resident #138 pulled the table away. Resident #113 continued to hold both hands out toward the table from 1:09 PM to 1:11 PM.</p> <p>Observation on 12/02/13 at 1:25 PM revealed Resident #113's lunch meal tray remained on the meal cart. At 1:26 PM, Nurse Aide #6 pushed the cart off of the nursing unit.</p> <p>Interview with NA #6 at 1:28 PM revealed she was taking the cart to the kitchen. NA # 6</p>	F 325	<p><u>Criteria 3</u></p> <p>The Staff Development Coordinator or designee will re-educate all Nursing staff on timely and accurate meal service including tray distribution and verification of receipt by all residents. This re-education will be completed by 1/2/14. The Unit Manager will randomly observe residents and meal carts for accurate tray distribution, 3 times per week for 4 weeks then monthly for 2 months. Opportunities will be corrected as identified.</p> <p><u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>		

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F 325	Continued From page 22 reported all residents had received the lunch meal including Resident #113. Observation on 12/02/13 at 1:29 PM revealed Resident #113's lunch meal remained on the cart. During this observation, NA #6 reported she did not realize Resident #113 did not receive the lunch meal. NA #6 explained Resident #113 required total assistance with eating and no specific staff member was assigned for eating assistance. Observation on 12/02/13 at 1:30 PM revealed NA #6 assisted Resident #113 with the lunch meal. Resident # 133 consumed 75% of the lunch meal. Interview with NA #7 on 12/02/13 at 1:34 PM revealed although Resident #113 was her assigned resident, meal assistance was not specifically assigned. NA #7 explained she did not know Resident #113 did not receive a lunch meal. Interview with Nurse #3 on 12/04/13 at 4:07 PM revealed Resident #113 should receive meals and assistance. Nurse #3 reported assistance with meals was a shared responsibility of nursing staff. Nurse #3 reported Resident #113 usually received meals in the main dining room. Interview with the Director of Nursing on 12/04/13 at 4:16 PM revealed she expected staff to deliver and provide assistance with meals.	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		

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F 332	<p>Continued From page 23 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility had a medication administration error rate of 8.00% and 2 non-significant errors were observed during the 25 opportunities. Miralax (a bulk laxative) was not given with required amount of fluid and mouth rinse was not provided after Advair discus administration. (Resident #61 and 24)</p> <p>The findings are: 1. Resident #61 was admitted to the facility on 6/6/13. Resident #61's diagnoses included constipation, chronic ischemic heart disease, Osteoarthritis and dementia. A review of the current physician orders dated 8/8/13 Included: 'Polyethylene glycol 3350 17 gram Powder in packet (Miralax 17 gram powder in packet) by mouth (PO) QD (once daily) section A for Constipation Mix with 8 oz (ounce) water'</p> <p>This was ordered with several other oral medications in the morning. Further review of the Medication Administration Record (MAR) revealed that it was scheduled at 8:00 AM in the morning.</p> <p>Resident #61 was observed for medication administration on 12/4/13 at 8:22 AM and nurse #1 was seen administering medications. Nurse #1 was seen pulling medications including a capful (17 gram) of Miralax for Resident #61 and dissolved Miralax in 4 ounce of water and stirred.</p>	F 332	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>F332</p> <p><u>Criteria 1</u></p> <p>.A Medication Variance report was completed by the Director of Nursing on 12/5/13 for the identified errors for Residents #61 and 24. The Physicians were notified and no new orders were received.</p> <p><u>Criteria 2</u></p> <p>All residents receiving Miralax and Advair have the potential for being affected by this alleged deficient practice</p>	

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F 332	<p>Continued From page 24</p> <p>She administered all oral medications and gave the Miralax 4 ounce solution to help swallow.</p> <p>An interview with Nurse #1 on 12/4/13 at 8:25 AM revealed that she did not read the complete instructions of the order for administering Miralax and had forgotten to dissolve it in correct amount of fluid. Nurse #1 also stated that she also failed to read the instructions printed in the pharmacy label and did not dissolve Miralax in 8 ounce of water or any other fluid as required.</p> <p>An interview with the Director of Nursing (DON) on 12/5/13 at 11:00 AM revealed that it was her expectation that all nurses were to read instructions in the MAR and on the pharmacy label prior to medication administration.</p> <p>2. Resident #24 was admitted to the facility on 8/26/12. Resident #21's diagnoses included Chronic Airway obstruction, obstructive sleep apnea, urinary tract infections, morbid obesity and depressive disorders. A review of the current physician orders dated 8/26/12 included:</p> <p>'Fluticasone-salmeterol 250 mcg (microgram)-50 mcg/dose Disk with Device (Advair Diskus 250 mcg-50 mcg Disk with Device) 1 Puff(s) by mouth (PO) BID (two times daily)' .</p> <p>This medication was scheduled to be administered with other oral medications in the morning. Further review of the Medication Administration Record (MAR) revealed that it was scheduled at 8:00 AM and 4:00 PM.</p> <p>Resident #24 was observed for medication administration on 12/4/13 at 8:50 AM and Nurse</p>	F 332	<p><u>Criteria 3</u></p> <p>The Staff Development Coordinator or designee will re-educate Licensed Nurses and Certified Medication Aides regarding Medication Administration according to the physician's orders to include liquid requirements when administering Miralax and rinsing the mouth following administration of Advair. This re-education will be completed by 1/2/14. The Staff Development Coordinator will observe a medication pass with 5 Licensed Nurses or Certified Medication Aides weekly for 4 weeks and monthly for 2 months to verify accurate medication administration. Opportunities will be corrected as identified.</p> <p><u>Criteria 4</u></p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing, the committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance: 1/2/14</p>	

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F 332	<p>Continued From page 25</p> <p>#2 was seen administering all medications including Advair Diskus. Nurse #2 was seen giving the medications and handed the prepared Advair Diskus unit at the end to Resident #24 and walked away after the administration. Nurse #2 failed to offer any mouth rinse after the use of Advair as instructed on the pharmacy instruction label.</p> <p>An interview with Nurse #2 on 12/4/13 at 9:05 AM stated that she forgot to offer the rinse to Resident #24. Nurse #2 stated that she normally does not work on the hall and had forgotten to offer mouth rinse to avoid any oral thrush.</p> <p>An interview with the Director of Nursing (DON) on 12/5/13 at 11:10 AM revealed that all nursing staff had been educated to rinse the mouth after the use of steroid based inhalers. The DON also stated that it was her expectation that the nursing staff to read the complete instructions on the pharmacy label.</p>	F 332			