JUL 28 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	07/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/EDEN	226 N OAKLAND AVENUE EDEN, NC 27288

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F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the physician	F 157	1. Residents identified to be affected by the alleged deficient practice. Resident #1 transferred to Morehead Memorial Hospital on December 8, 2010 at 10:00am related to acute changes in his clinical status. This resident was admitted to Morehead Memorial Hospital diagnosis with a small bowel obstruction with perforation and was placed on comfort measures and released back to Brian Center of Eden on December 15, 2010 with a continuation of his orders; therefore, no further corrective action could be accomplished. On July 6, 2011 the facility's interim Director of Nursing began an investigation into the facts surrounding the resident's discharge on December 8, 2010. The investigation continued until July 7, 2011. This investigation included	7-27-11

Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Helen D. Myers	Administrator	7-27-11

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 157	Continued From page 1 of a change in condition for one (1) of two (2) sampled residents (Resident #1) when Resident #1 complained of abdominal pain, exhibited nausea and vomiting and was noted to have no bowel sounds when examined by nursing staff. Immediate jeopardy began on 12/04/2010 and was identified on 07/07/2011 at 11:20 AM. Immediate Jeopardy was removed on 07/07/2011 at 6:39 P.M., when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #1 was admitted to the facility on 05/14/2004. Resident #1 had a hospitalization 11/23/2010-11/30/2010 with diagnoses of right lower lobe pneumonia, fracture of the right femur. Hospital discharge summary dated 11/30/2010 stated Resident #1 developed an ileus (obstruction of the bowel) during his hospitalization probably secondary to pneumonia. He was treated with large doses of Miralax (laxative), eventually improved and his bowels were moving regularly on discharge from the hospital. Physician orders were reviewed and revealed a physician order dated 11/30/2010 for Vicodin 5-500 tab one (1) tablet po.(by mouth) every for (4) hours for pain. Lexi-Comp's Geriatric Dosage Handbook 12th edition indicated that constipation was a side effect of the medication.	F 157	details regarding the discharge of Resident #1 on December 8, 2010. Director of Nursing and Staff Development Coordinator provided one-to-one education in regards to communicating with supervisors regarding notification of change in condition, including incidents of constipation, nausea, and vomiting, and completion of change of condition forms, InterAct II, when to report to the MD/PA/NP, and following the chain of command. On July 7, 2011, the Staff Development Coordinator initiated education for all licensed nurses regarding notification of change in condition and assessment of a resident specifically related to constipation, nausea, and vomiting, and assessments in relation to change of condition and reporting and will be completed by July 12, 2011 to include those staff on vacation and work only weekends. On July 7, 2011, all available Certified Nursing Assistants were educated on	

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F 157	Continued From page 2 A care plan dated 09/28/2010 indicated Resident #1 had a potential for alteration in bowel function with episodes of constipation related to medication. Approaches included: encourage fluids, observe for bowel pattern to ensure adequate bowel elimination and notification of physician as indicated. A review of the Bladder and Bowel report sheet for 11/26/2010 through 12/8/2010 revealed Resident #1 had a documented bowel movement on 12/1/2010 and 12/4/2010. Complete Blood \count (CBC) results obtained on 12/2/2010 indicated a white cell count of 13.8 On 12/04/2010 at 06:00 AM., nursing notes stated Resident #1 was experiencing some chronic constipation. An enema was given at 01:00 AM. with no results. The nurse's note indicated Resident #1 had vomited undigested food three times and staff attempted to give Resident #1 warm prune juice, but Resident #1 could not keep it down. Vital signs were temperature- 97.4, pulse-72, respirations-20 and blood pressure 168/87. On 12/04/2010 at 1:30 PM., nursing notes indicated Resident #1 said he had not used the bathroom for three days. Resident #1 vomited liquid one time. He was given an enema and a medium soft stool was noted after the enema was given. The documentation indicated Resident #1's abdomen was distended and firm to touch with complaints of pain when his stomach was touched. No bowel sounds were heard in any areas of the stomach after the bowel movement. Vital signs were temperature-99.6, pulse-75,	F 157	communicating with supervisors regarding change in condition including incidents of constipation and completion of Change of Condition forms and will be completed by July 12, 2011 to include those staff on vacation and work weekends only. An impromptu meeting of the Quality Assessment and Assurance including the Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Resident Care Management Director, and Medical Director was conducted at the Brian Center of Eden on July 7, 2011 at 12:50pm to implement a plan of action regarding the alleged deficient practice. Starting the week of July 11, 2011 the facility Quality Assessment and Assurance Committee will meet weekly for a period of three weeks to review actions associated with notification of change in resident status. Going forward, the Quality Assessment and Assurance Committee, to include the Interdisciplinary Team (including the	

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F 157	Continued From page 3 respirations-18 and blood pressure 121/70. On 12/05/2010 at 12:30 PM., nursing noted stated Resident #1 was coughing, spitting up frothy brown sputum and only took liquids for breakfast. He complained of nausea and stomach pain. His abdomen was distended and firm to touch and hypoactive bowel sounds were noted in all areas of the stomach. Vital signs were temperature-97.1, pulse-68, respirations-16 and blood pressure 140/72. At 4:00 PM., Resident #1 had nausea and vomiting. Vital signs were temperature-99.1 axillary, pulse-67, respirations-24 and blood pressure 132/64. On Monday, 12/6/2010 at 05:45 AM., nursing notes stated "Resident #1 appears to be having some hydration problems. His PO (oral) intake had decreased and he's had episodes of nausea/vomiting over 48 (forty-eight) hours. His abdomen is somewhat distended. On 12/4 and 12/5 he experienced severe constipation. Enemas given x 2 and effective. Currently he's taking Lasix 80 mg. BID (twice daily) and Avapro 300 mg. His urine is a dark/amber tome without foul odor. 12/5/10 he experienced an elevated temp. (temperature) which was treated with Tylenol and ice chips." On 12/6/2010 at 7:09AM, Resident #1's physician was notified via fax. Information noted on the fax stated "Resident #1's oral intake decreased. Due to dysphagia, he's on thickened liquids which he does not like. The last 48 (forty-eight) hours, he's had episodes of nausea/vomiting. 12/5-12/5 severe constipation. Treated with enema x 2 (effective). 12/5 temp (temperature) elevated. Urine dark/amber. Skin turgor poor. Currently	F 157	Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) will meet monthly or as needed. 2. Residents with the potential to be affected by the alleged deficient practice. Residents who exhibit acute changes in condition requiring intervention, such as constipation, have the potential to be affected by the alleged deficient practice. On July 7, 2011, the Director of Nursing began a review of the current residents who have had an acute change in condition requiring notification. On July 7, 2011, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented, and communicated to the appropriate parties. Two residents were noted with skin tears and the interventions were as Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 157	Continued From page 4 taking Lasix 80 mg. BID, Avapro 300 mg. qd (daily)." Resident #1's physician ordered a complete blood count (CBC) with differential and a complete metabolic panel (CMET). On 12/6/2010, CBC results indicated a white cell count of 19.1 (normal 4.0-10.5). This was increased from the result received four days earlier. On 12/6/2010 at 9:40 PM., nursing notes stated Resident #1 complained of nausea and was given Phenergan 25 mg. intramuscularly (IM). Vital signs were temperature-97.9, pulse-65, respirations-24 and blood pressure 115.62. On 12/7/2010 at 1:30 PM., vital signs were temperature 97.1, pulse-72, respirations-20 and blood pressure 156/103. Resident #1 continued to spit up frothy sputum, complained of feeling bad and refused breakfast. No bowel movement was noted. At 8:45 PM., Resident #1 vomited yellowish liquid and was given Phenergan with no further vomiting noted. A Quarterly Minimum Data Set assessment dated 12/07/2010 indicated Resident #1 received pain medication as needed. The assessment stated Resident #1 experienced occasional mild pain that affected day to day activities and sleep. Constipation was not indicated on the assessment. On 12/8/2010 at 06:00 AM., nursing notes stated Resident #1 vomited liquid that was phlegm in appearance. Vital signs were temperature 99.5, pulse-71, respirations-28 and blood pressure 95/51. At 11:00 AM., vital signs were temperature-97.4, pulse-76, respirations-26 and blood pressure-108-59. He had vomited twice	F 157	follows: treatment initiated, MD and RP notification, identification of the underlying cause with correction. Appropriate notification and treatments initiated and completed for both residents. . 3. Systemic Measures On July 7, 2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Resident Care Management Director, and MDS Coordinator) to review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24 hour reports, change of condition forms, Bowel records, and telephone orders. Adjustments to the plan of care and Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 157	Continued From page 5 that morning and had been unable to eat breakfast. Morning medications were vomited. Resident #1 was moaning. His abdomen was distended and very hard. Resident #1's physician was notified and he was sent to (name) hospital at 10:00 AM. Resident #1 was admitted to (name) hospital on 12/8/2010 with a diagnosis of high grade small bowel obstruction with perforation. The Hospital discharge summary dated 12/15/2010 included a discharge diagnosis of high-grade small bowel obstruction with perforation present on admission (12/08/2010). X-rays done on admission revealed a high-grade small bowel obstruction with free intraperitoneal air consistent with perforation. Nurse #3 worked night shift (11:00 PM.-07:00 AM.) and provided care for Resident #1 on 12/4, 12/6, 12/7 and 12/8/2010. On 07/6/2011 at 3:15 PM., she stated it was not abnormal for Resident #1 to complain of stomach pain and/or become constipated due to pain medication. Nurse #3 said she received reports of Resident #1 being constipated and nausea and vomiting. Nurse #3 stated, on 12/04/2010 at 01:00 AM., Resident #1's abdomen was distended and hard. She listened to his abdomen and noted very little bowel sounds. She could not press on Resident #1's abdomen because he complained of pain and that was "different" for him. She said she checked the rectum and felt a solid mass of stool. Constipation was the first thing that came to her mind and Resident #1 was given an enema per standing orders for constipation. Nurse #3 stated she did not notify the physician on 12/4/2010 at 6:00 AM. because Resident #1 had vomited only	F 157	Care Assignment Sheets will be made based on these reviews and the input of medical professionals. On July 7, 2011, the facility initiated a mechanism to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty and/or charge nurse. The Director of Nursing or Administrator will be called to discuss findings and initiate further action as appropriate. The Quality Assessment and Assurance Committee will monitor the process daily Monday thru Friday for a period of 4 weeks, then weekly for a period of 4 weeks, then randomly as deemed necessary by the Quality Assessment and Assurance Committee. On July 7, 2011, the Regional Clinical Director, the Director of Nursing, and the Staff Development Coordinator conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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

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F 157	Continued From page 6 one time and the standard protocol was to monitor for twenty-four (24) to seventy-two (72) hours before faxing/calling the physician. Nurse #2 worked evening shift (3:00 PM.-11:00 PM.) and provided care for Resident #1 on 12/4, 12/5 and 12/6/2010. On 07/6/2011 at 3:35 PM., she stated Resident #1 had complaints of leg pain nausea and vomiting on his return from the hospital on 11/30/2010. Nurse #2 stated the physician would be notified by telephone or fax if nausea and vomiting continued for more than one day. Nurse #2 stated she did not notify the physician regarding the nausea and vomiting because Resident #1 was not vomiting every shift. Nurse #4 worked day shift (07:00 AM.-3:00 PM.) and provided care for Resident #1 on 12/6 and 12/8/2010. On 07/6/2011 at 4:35 PM., she stated she notified the physician on 12/6/2010 that Resident #1 vomited almost everything that was given him and the family was concerned about Resident #1's condition. Nurse #4 stated she could not remember if she also notified the physician about Resident #1's distended abdomen, complaints of abdominal pain or the absence of bowel sounds on 12/4/2010. Nurse #4 stated she was aware that Resident #1 had a diagnosis of ileus from his previous hospitalization in November 2010 and nursing staff monitored vomiting, constipation, loose stools, abdominal distention and bowel sounds every shift. This would be documented in the nursing notes or on the daily skilled nursing sheets. Nurse #4 stated Resident #1 displayed signs of increased pain on 12/8/2010. She stated Resident #1 was moaning loudly and began	F 157	assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and continuity of care. The Director of Nursing, Resident Care Management Director, or Staff Development Coordinator will provide all licensed nursing staff education prior to being allowed to work. This education will be included in the facility's new hire orientation. Beginning July 7, 2011, scheduled Certified Nursing Assistants were educated regarding notification of the Nurse when a resident experiences a change in condition, including but not limited to constipation, nausea, and vomiting. Certified Nursing Assistant's will be provided this education via the Director of Nursing, Resident Care Management Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 157	Continued From page 7 vomiting. She notified the physician at that time and Resident #1 was transferred to the hospital. On 07/6/2011 at 5:30 PM., the interim Director of Nursing stated any change in resident condition would be documented on the 24 hour report sheet. The report sheets for December 2010 had been shredded but she would expect any information that had been on the 24 hour report sheet to be documented in the resident's chart. The interim Director of Nursing stated nursing staff followed a flip chart to determine what to do in certain situations. She obtained the flip chart from the nurse's desk, referred to the "constipation" section and stated it informed nursing staff on what to document and not when and/or who to notify in any situation. When asked regarding the nursing notes written on 12/4/2010 at 1:30 PM., the interim Director of Nursing stated, she would expect the nursing staff to notify the administrative nurse on call who was available at all times for further help in assessment. She stated, with nausea, vomiting, constipation and no bowel sounds, she would expect the physician to be notified at that time. Nurse #1 worked day shift (07:00 AM.-3:00 PM.) and provided care for Resident #1 on 12/4, 12/5 and 12/7/2010. On 07/7/2011 at 8:55 AM., Nurse #1 stated Resident #1's abdomen was distended and no bowel sounds were heard when she examined him on 12/4/2010 at 1:30 PM. She did not notify the physician because Resident #1's abdomen "was always distended and tender to touch. It was normal for him to have diminished or no bowel sounds." Nurse #1 stated the physician had always been aware that Resident #1's abdomen was distended. She said she	F 157	Director, or Staff Development Coordinator prior to being allowed to work. In addition, on July 7, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Staff Development Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need. The Director of Nursing and Regional Clinical Director conducted grand rounds on July 7, 2011. Residents were reviewed to assess for additional needs and interventions. The	

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F 157	Continued From page 8 would have notified the physician for pain medication if Resident #1 had continued profusely vomiting, had an elevated temperature, was in severe pain and/or not voiding. She indicated as long as Resident #1 was voiding and not vomiting, she had no concerns. On 07/7/2011 at 7:10 PM., Resident #1's physician stated it was not normal for Resident #1 to have a distended abdomen, abdominal pain or diminished/ no bowel sounds. He said he would expect to be notified if there was any question of pain, potential for blockage, vomiting, fecal material in the vomitus, tender or distended abdomen and absence or hyperactive bowel sounds. Resident #1's physician stated that a complete bowel obstruction and perforation was a lot different that an ileus and it was miraculous that Resident #1 survived. The physician stated, if he had been called on 12/4/2010 and told the information noted in the nursing notes (nausea and vomiting, abdomen distended and firm, complaints of abdominal pain, no bowel sounds), he would have told the facility to transfer the resident to the hospital for evaluation. The Administrator was notified of the Immediate Jeopardy on 07/07/2011 at 11:20 AM. The facility presented a credible allegation of compliance on 07/07/2011 at 6:39 PM. which included: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 transferred to the hospital on	F 157	Director of Nursing and Regional Clinical Director also reviewed the documentation in the medical records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns. Additional measures put into place to ensure the alleged deficient practice does not recur include: The Interdisciplinary Team (IDT) will review bowel reports on a daily basis Monday through Friday during the IDT meeting to ensure any change in condition is identified. Appropriate interventions and notifications will be made based on these reviews. The Director of Nursing, RCMD, and/or Staff Development Coordinator will review 24-hour reports daily, Monday through Friday, to identify any change in resident's condition. Additionally, the licensed nurses will be educated annually on nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 157	Continued From page 9 December 8, 2010 at 10:00am related to acute changes in his clinical status. This resident was admitted to the hospital with a diagnosis of a small bowel obstruction with perforation and was placed on comfort measures and released back to Brian Center of Eden on December 15, 2010 with a continuation of his orders; therefore, no further corrective action could be accomplished. On July 6, 2011 the facility's interim Director of Nursing began an investigation into the facts surrounding the resident's discharge on December 8, 2010. The investigation continued until July 7, 2011. This investigation included details regarding the discharge of Resident #1 on December 8, 2010. Director of Nursing and Staff Development Coordinator provided one-to-one education in regards to communicating with supervisors regarding notification of change in condition, including incidents of constipation, nausea, and vomiting, and completion of change of condition forms, InterAct II (Interventions to reduce acute care transfers), when to report to the MD/PA/NP, and following the chain of command. On July 7, 2011, the Staff Development Coordinator initiated education for all licensed nurses regarding notification of change in condition and assessment of a resident specifically related to constipation, nausea, and vomiting, and assessments in relation to change of condition and reporting and will be completed by July 12, 2011 to include those staff on vacation and work only weekends. On July 7, 2011, all available Certified Nursing Assistants were educated on communicating with supervisors	F 157	for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition to ensure continued compliance. 4. Quality Assessment and Assurance On July 7, 2011, the Quality Assessment and Assurance Committee, including the facility Administrator, Human Resources Coordinator, Director of Nursing, Resident Care Management Director, MDS Coordinator, Maintenance Director, Social Worker, Activities Director, Therapy Program Manager, Medical Records Coordinator, and Dietary Manager to discuss the acute episode experienced by Resident #1 on December 4, 2011. The Committee also has reviewed this acute episode with the facility's Medical Director. Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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	345241	A. BUILDING _____ B. WING _____	07/08/2011

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F 157	Continued From page 10 regarding change in condition including incidents of constipation and completion of Change of Condition forms and will be completed by July 12, 2011 to include those staff on vacation and work weekends only. An impromptu meeting of the Quality Assessment and Assurance including the Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Resident Care Management Director, and Medical Director was conducted at the Brian Center of Eden on July 7, 2011 at 12:50pm to implement a plan of action regarding the alleged deficient practice. Starting the week of July 11, 2011 the facility Quality Assessment and Assurance Committee will meet weekly for a period of three weeks to review actions associated with notification of change in resident status. Going forward, the Quality Assessment and Assurance Committee, to include the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) will meet monthly or as needed. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Residents who exhibit acute changes in condition requiring intervention, such as constipation, have the potential to be affected by the alleged deficient practice. On July 7, 2011, the Director of Nursing began a review of the current residents who have had an acute change in condition	F 157	On July 7, 2011, the Committee has reviewed the education materials provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. The Administrator and/or Director of Nursing will review data obtained during reviews and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 157	Continued From page 11 requiring notification. On July 7, 2011, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented, and communicated to the appropriate parties. Two residents were noted with skin tears and the interventions were as follows: treatment initiated, MD and RP notification, identification of the underlying cause with correction. Appropriate notification and treatments initiated and completed for both residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: On July 7, 2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Resident Care Management Director, and MDS Coordinator) to review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24 hour reports, change of condition forms, Bowel records, and telephone orders. Adjustments to the plan of care and Care Assignment Sheets will be made based on these reviews and the input of medical professionals. On July 7, 2011, the facility initiated a mechanism to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty	F 157		

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F 157	Continued From page 12 and/or charge nurse. The Director of Nursing or Administrator will be called to discuss findings and initiate further action as appropriate. The Quality Assessment and Assurance Committee will monitor the process daily Monday thru Friday for a period of 4 weeks, then weekly for a period of 4 weeks, then randomly as deemed necessary by the Quality Assessment and Assurance Committee. On July 7, 2011, the Regional Clinical Director, the Director of Nursing, and the Staff Development Coordinator conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and continuity of care. The Director of Nursing, Resident Care Management Director, or Staff Development Coordinator will provide all licensed nursing staff education prior to being allowed to work. This education will be included in the facility's new hire orientation. Beginning July 7, 2011, scheduled Certified Nursing Assistants were educated regarding notification of the Nurse when a resident experiences a change in condition, including but not limited to constipation, nausea, and vomiting. Certified Nursing Assistants will be provided this education via the Director of Nursing, Resident Care Management Director, or Staff Development Coordinator prior	F 157		

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F 157	Continued From page 13 to being allowed to work. In addition, on July 7, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Staff Development Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need. The Director of Nursing and Regional Clinical Director conducted grand rounds on July 7, 2011. Residents were reviewed to assess for additional needs and interventions. The Director of Nursing and Regional Clinical Director also reviewed the documentation in the medical records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns. Additional measures put into place to ensure the alleged deficient practice does not recur include: The Interdisciplinary Team (IDT) will review bowel reports on a daily basis Monday through Friday during the IDT meeting to ensure any change in condition is identified. Appropriate interventions and notifications will be made based on these reviews. The Director of Nursing, RCMD, and/or Staff Development Coordinator will review 24-hour reports daily, Monday through Friday, to identify any change in resident's condition. Additionally, the licensed nurses will be educated annually on nursing assessment, post-change of	F 157		

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F 157	Continued From page 14 condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition to ensure continued compliance. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility: On July 7, 2011, the Quality Assessment and Assurance Committee (QA&A), including the facility Administrator, Human Resources Coordinator, Director of Nursing, Resident Care Management Director, MDS(Minimum Data Set) Coordinator, Maintenance Director, Social Worker, Activities Director, Therapy Program Manager, Medical Records Coordinator, and Dietary Manager to discuss the acute episode experienced by Resident #1 on December 4, 2011. The Committee also has reviewed this acute episode with the facility ' s Medical Director. On July 7, 2011, the Committee has reviewed the education materials provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. The Administrator and/or Director of Nursing will review data obtained during reviews and report	F 157		

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F 157	Continued From page 15 patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. Immediate Jeopardy was removed on 07/07/2011 at 6:39 PM. Interviews with licensed nursing staff confirmed they had received in-servicing on nursing assessment, use of InterAct II tools as guideline for assessment and when/ whom to notify for acute changes in resident condition. Documentation was provided by the facility that in-servicing began on 07/07/2011 and copies were provided of the tools that would be used as a guideline for assessment.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and physician interviews, the facility failed to continue to assess and monitor new onset of abdominal pain with associated nausea and vomiting, distended abdomen and absence of bowel sounds for one (1) of two (2) sampled residents (Resident #1) which resulted in hospitalization for	F 309		

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F 309	Continued From page 16 small bowel obstruction with perforation. Immediate jeopardy began on 12/04/2010 and was identified on 07/07/2011 at 11:20 AM. Immediate Jeopardy was removed on 07/07/2011 at 6:39 PM. when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #1 was admitted to the facility on 05/14/2004. Resident #1 had a hospitalization 11/23/2010-11/30/2010 with diagnoses of right lower lobe pneumonia, fracture of the right femur. Hospital discharge summary dated 11/30/2010 stated Resident #1 developed an ileus (obstruction of the bowel) during his hospitalization probably secondary to pneumonia. He was treated with large doses of Miralax (laxative), eventually improved and his bowels were moving regularly on discharge from the hospital. Physician orders were reviewed and revealed a physician order dated 11/30/2010 for Vicodin 5-500 tab one (1) tablet po.(by mouth) every for (4) hours for pain. Lexi-Comp's Geriatric Dosage Handbook 12th edition indicated that constipation was a side effect of the medication. A care plan dated 09/28/2010 indicated Resident #1 had a potential for alteration in bowel function with episodes of constipation related to medication. Approaches included: encourage	F 309	7-22-11 1. Residents identified to be affected by the alleged deficient practice. Resident #1 transferred to Morehead Memorial Hospital on December 8, 2010 at 10:00am related to acute changes in his clinical status. This resident was admitted to Morehead Memorial Hospital diagnosis with a small bowel obstruction with perforation and was placed on comfort measures and released back to Brian Center of Eden on December 15, 2010 with a continuation of his orders; therefore, no further corrective action could be accomplished. On July 6, 2011 the facility's interim Director of Nursing began an investigation into the facts surrounding the resident's discharge on December 8, 2010. The investigation continued until July 7, 2011. This investigation included details regarding the discharge of Resident #1 on December 8, 2010. Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 17 fluids, observe for bowel pattern to ensure adequate bowel elimination and notification of physician as indicated. A review of the Bladder and Bowel report sheet for 11/26/2010 through 12/8/2010 revealed Resident #1 had a documented bowel movement on 12/1/2010 and 12/4/2010. On 12/04/2010 at 06:00 AM., nursing notes stated Resident #1 was experiencing some chronic constipation. An enema was given at 01:00 AM. with no results. Resident #1 had vomited undigested food three times. Nursing staff attempted to give Resident #1 warm prune juice but Resident #1 could not keep it down. Vital signs were temperature- 97.4, pulse-72, respirations-20 and blood pressure 168/87. On 12/04/2010 at 1:30 PM., nursing notes stated Resident #1 said he had not used the bathroom for three days. Resident #1 vomited liquid one time. He was given an enema and a medium soft stool was noted after the enema was given. Resident #1's abdomen was distended and firm to touch with complaints of pain when his stomach was touched. No bowel sounds were heard in any areas of the stomach after the bowel movement. Vital signs were temperature-99.6, pulse-75, respirations-18 and blood pressure 121/70. On 12/5/2010 at 12:30 PM., nursing notes stated Resident #1 was coughing and spitting up frothy brown sputum and only took liquids for breakfast. Hypoactive bowel sounds were noted in all areas of the stomach. His abdomen was distended and firm to touch. Resident #1 complained of nausea	F 309	Director of Nursing and Staff Development Coordinator provided one-to-one education in regards to resident assessment and communicating with supervisors regarding change in condition, including incidents of constipation, nausea, and vomiting, and completion of change of condition forms, InterAct II, when to report to the MD/PA/NP, and following the chain of command. On July 7, 2011, the Staff Development Coordinator initiated education for all licensed nurses regarding assessment of a resident specifically related to constipation, nausea, and vomiting, and assessments in relation to change of condition and reporting and will be completed by July 12, 2011 to include those staff on vacation and work only weekends. On July 7, 2011, all available Certified Nursing Assistants were educated on communicating with supervisors regarding change in condition Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 18 and of stomach pain. Phenergan 25 milligrams (mg) was administered by mouth. Vital signs were temperature-97.1, pulse-68, respirations-16 and blood pressure 140/72. On 12/5/2010 at 4:00 PM., nursing notes stated Resident #1 had nausea and vomiting one time. Phenergan 25 mg. suppository and Tylenol suppository was given. Vital signs were temperature-99.1 axillary, pulse-67, respirations-24 and blood pressure 132/64. On 12/6/2010 at 05:45 AM., nursing notes stated "Resident #1 appears to be having some hydration problems. His PO (oral) intake had decreased and he's had episodes of nausea/vomiting over 48 (forty-eight) hours. His abdomen is somewhat distended. On 12/4 and 12/5 he experienced severe constipation. Enemas given x 2 and effective. Currently he's taking Lasix 80 mg. BID (twice daily) and Avapro 300 mg. His urine is a dark/amber tome without foul odor. 12/5/10 he experienced an elevated temp. (temperature) which was treated with Tylenol and ice chips." On 12/6/2010 at 9:40 PM., nursing notes stated Resident #1 complained of nausea and Phenergan 25 mg.intramuscularly (IM) was given and noted to be effective. Vital signs were temperature-97.9, pulse-65, respirations-24 and blood pressure 115/62. On 12/7/2010 at 1:30 PM., vital signs were temperature 97.1, pulse-72, respirations-20 and blood pressure 156/103. Resident #1 continued to spit up frothy sputum and complained of feeling bad. No bowel movement was noted. Breakfast	F 309	including incidents of constipation and completion of Change of Condition forms and will be completed by July 12, 2011 to include those staff on vacation and work weekends only. An impromptu meeting of the Quality Assessment and Assurance including the Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Resident Care Management Director, and Medical Director was conducted at the Brian Center of Eden on July 7, 2011 at 12:50pm to implement a plan of action regarding the alleged deficient practice. Starting the week of July 11, 2011 the facility Quality Assessment and Assurance Committee will meet weekly for a period of three weeks to review actions associated with notification of change in resident status. Going forward, the Quality Assessment and Assurance Committee, to include the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 19 was refused but liquids were consumed well. On 12/7/2010 at 8:45 PM., nursing notes stated Resident #1 vomited yellowish liquid. Only twenty-five (25) per cent of the meal was consumed. Phenergan 25 mg. was given with no further vomiting noted. Vital signs were temperature-97.4, pulse-76, respirations-26 and blood pressure 134/56. A Quarterly Minimum Data Set assessment dated 12/07/201 indicated Resident #1 received pain medication as needed. The assessment stated Resident #1 experienced occasional mild pain that affected day to day activities and sleep. Constipation was not indicated on the assessment. On 12/8/2010 at 06:00 AM., nursing notes stated Resident #1 vomited liquid that was phlegm in appearance. Vital signs were temperature-99.5, pulse-71, respirations-28 and blood pressure 95/51. On 12/8/2010 at 11:00 AM., nursing notes stated vital signs were temperature-97.4, pulse-76, respirations-26 and blood pressure-108/59. Resident #1 had vomited twice that morning and had been unable to eat breakfast. Morning medications were vomited. Resident #1 was moaning. Abdomen was distended and very hard. Resident #1's physician was notified and Resident #1 was sent to (name) hospital at 10:00 AM. Resident #1 was admitted to (name) hospital on 12/8/2010 with a diagnosis of high grade small bowel obstruction with perforation. Hospital discharge summary dated 12/15/2010	F 309	Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) will meet monthly or as needed. 2. Residents with the potential to be affected by the alleged deficient practice. Residents who exhibit acute changes in condition requiring intervention, such as constipation, have the potential to be affected by the alleged deficient practice. On July 7, 2011, the Director of Nursing began a review of the current residents who have had an acute change in condition requiring notification. On July 7, 2011, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented, and communicated to the appropriate parties. Two residents were noted with skin tears and the interventions were as follows: treatment initiated, MD and RP notification, identification of the	

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F 309	Continued From page 20 included a discharge diagnosis of high-grade small bowel obstruction with perforation present on admission (12/08/2010). X-rays done on admission revealed a high-grade small bowel obstruction with free intraperitoneal air consistent with perforation. Nurse #3 worked night shift (11:00 PM.-07:00 AM.) and provided care for Resident #1 on 12/4, 12/6, 12/7 and 12/8/2010. On 07/6/2011 at 3:15 PM., she stated it was not abnormal for Resident #1 to complain of stomach pain and/or become constipated due to pain medication. Nurse #3 said she received reports of Resident #1 being constipated and nausea and vomiting. Nurse #3 stated, on 12/04/2010 at 01:00 AM., Resident #1's abdomen was distended and hard. She listened to his abdomen and noted very little bowel sounds. She could not press on Resident #1's abdomen because he complained of pain and that was "different" for him. She said she checked the rectum and felt a solid mass of stool. Constipation was the first thing that came to her mind and Resident #1 was given an enema per standing orders for constipation. Nurse #3 stated she did not notify the physician on 12/4/2010 at 6:00 AM. because Resident #1 had vomited only one time and the standard protocol was to monitor for twenty-four (24) to seventy-two (72) hours before faxing/ calling the physician. Nurse #2 worked evening shift (3:00 PM.-11:00 PM.) and provided care for Resident #1 on 12/4, 12/5 and 12/6/2010. On 07/6/2011 at 3:35 PM., she stated Resident #1 had complaints of leg pain nausea and vomiting on his return from the hospital on 11/30/2010. Nurse #2 stated the	F 309	underlying cause with correction. Appropriate notification and treatments initiated and completed for both residents. . 3. Systemic Measures On July 7, 2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Resident Care Management Director, and MDS Coordinator) to review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24 hour reports, change of condition forms, Bowel records, and telephone orders. Adjustments to the plan of care and Care Assignment Sheets will be made based on these reviews and the	

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	345241	A. BUILDING _____ B. WING _____	07/08/2011

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F 309	Continued From page 21 physician would be notified by telephone or fax if nausea and vomiting continued for more than one day. Nurse #2 stated she did not notify the physician regarding the nausea and vomiting because Resident #1 was not vomiting every shift. Nurse #4 worked day shift (07:00 AM.-3:00 PM.) and provided care for Resident #1 on 12/6 and 12/8/2010. On 07/6/2011 at 4:35 PM., she stated she notified the physician on 12/6/2010 that Resident #1 vomited almost everything that was given him and the family was concerned about Resident #1's condition. Nurse #4 stated she could not remember if she also notified the physician about Resident #1's distended abdomen, complaints of abdominal pain or the absence of bowel sounds on 12/4/2010. Nurse #4 stated she was aware that Resident #1 had a diagnosis of ileus from his previous hospitalization in November 2010 and nursing staff monitored vomiting, constipation, loose stools, abdominal distention and bowel sounds every shift. This would be documented in the nursing noted or on the daily skilled nursing sheets. Nurse #4 stated Resident #1 displayed signs of increased pain on 12/8/2010. She stated Resident #1 was moaning loudly and began vomiting. She notified the physician at that time and Resident #1 was transferred to the hospital. On 07/6/2011 at 5:30 PM., the interim Director of Nursing stated any change in resident condition would be documented on the 24 hour report sheet. The report sheets for December 2010 had been shredded but she would expect any information that had been on the 24 hour report sheet to be documented in the resident's chart.	F 309	input of medical professionals. On July 7, 2011, the facility initiated a mechanism to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty and/or charge nurse. The Director of Nursing or Administrator will be called to discuss findings and initiate further action as appropriate. The Quality Assessment and Assurance Committee will monitor the process daily Monday thru Friday for a period of 4 weeks, then weekly for a period of 4 weeks, then randomly as deemed necessary by the Quality Assessment and Assurance Committee. On July 7, 2011, the Regional Clinical Director, the Director of Nursing, and the Staff Development Coordinator conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition assessment, use of Interact II tools as	

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F 309	Continued From page 22 The interim Director of Nursing stated nursing staff followed a flip chart to determine what to do in certain situations. She obtained the flip chart from the nurse's desk, referred to the "constipation" section and stated it informed nursing staff on what to document and not when and/or who to notify in any situation. When asked regarding the nursing notes written on 12/4/2010 at 1:30 PM., the interim Director of Nursing stated, she would expect the nursing staff to notify the administrative nurse on call who was available at all times for further help in assessment. She stated, with nausea, vomiting, constipation and no bowel sounds, she would expect the physician to be notified at that time. Nurse #1 worked day shift (07:00 AM.-3:00 PM.) and provided care for Resident #1 on 12/4, 12/5 and 12/7/2010. On 07/7/2011 at 8:55 AM., Nurse #1 stated Resident #1's abdomen was distended and no bowel sounds were heard when she examined him on 12/4/2010 at 1:30 PM. She did not notify the physician because Resident #1's abdomen "was always distended and tender to touch. It was normal for him to have diminished or no bowel sounds." Nurse #1 stated the physician had always been aware that Resident #1's abdomen was distended. She said she would have notified the physician for pain medication if Resident #1 had continued profusely vomiting, had an elevated temperature, was in severe pain and/or not voiding. She indicated as long as Resident #1 was voiding and not vomiting, she had no concerns. On 07/07/2011 at 7:10 PM., Resident #1's attending physician stated Resident #1 required close monitoring for eating, bowel movements	F 309	guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and continuity of care. The Director of Nursing, Resident Care Management Director, or Staff Development Coordinator will provide all licensed nursing staff education prior to being allowed to work. This education will be included in the facility's new hire orientation. Beginning July 7, 2011, scheduled Certified Nursing Assistants were educated regarding notification of the Nurse when a resident experiences a change in condition, including but not limited to constipation, nausea, and vomiting. Certified Nursing Assistant's will be provided this education via the Director of Nursing, Resident Care Management Director, or Staff Development Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 23 and complaints of pain. He expected nursing staff to assess Resident #1 routinely for vomiting, fecal material in vomitus, abdominal tenderness, distended abdomen and absence or hyperactive bowel sounds The Administrator was notified of the Immediate Jeopardy on 07/07/2011 at 11:20 AM. The facility presented a credible allegation of compliance on 07/07/2011 at 6:39 PM. which included: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 transferred to the hospital on December 8, 2010 at 10:00am related to acute changes in his clinical status. This resident was admitted to the hospital diagnosis with a small bowel obstruction with perforation and was placed on comfort measures and released back to Brian Center of Eden on December 15, 2010 with a continuation of his orders; therefore, no further corrective action could be accomplished. On July 6, 2011 the facility's interim Director of Nursing began an investigation into the facts surrounding the resident's discharge on December 8, 2010. The investigation continued until July 7, 2011. This investigation included details regarding the discharge of Resident #1 on December 8, 2010. Director of Nursing and Staff Development Coordinator provided one-to-one education in regards to resident assessment and	F 309	Coordinator prior to being allowed to work. In addition, on July 7, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Staff Development Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need. The Director of Nursing and Regional Clinical Director conducted grand rounds on July 7, 2011. Residents were reviewed to assess for additional needs and interventions. The Director of Nursing and Regional	

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F 309	Continued From page 24 communicating with supervisors regarding change in condition, including incidents of constipation, nausea, and vomiting, and completion of change of condition forms, InterAct II(Interventions to reduce acute care transfers), when to report to the MD/PA/NP, and following the chain of command. On July 7, 2011, the Staff Development Coordinator initiated education for all licensed nurses regarding assessment of a resident specifically related to constipation, nausea, and vomiting, and assessments in relation to change of condition and reporting and will be completed by July 12, 2011 to include those staff on vacation and work only weekends. On July 7, 2011, all available Certified Nursing Assistants were educated on communicating with supervisors regarding change in condition including incidents of constipation and completion of Change of Condition forms and will be completed by July 12, 2011 to include those staff on vacation and work weekends only. An impromptu meeting of the Quality Assessment and Assurance including the Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Resident Care Management Director, and Medical Director was conducted at the Brian Center of Eden on July 7, 2011 at 12:50pm to implement a plan of action regarding the alleged deficient practice. Starting the week of July 11, 2011 the facility Quality Assessment and Assurance Committee will meet weekly for a period of three weeks to review actions associated with notification of change in resident status. Going forward, the Quality Assessment and Assurance Committee, to	F 309	Clinical Director also reviewed the documentation in the medical records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns. Additional measures put into place to ensure the alleged deficient practice does not recur include: The Interdisciplinary Team (IDT) will review bowel reports on a daily basis Monday through Friday during the IDT meeting to ensure any change in condition is identified. Appropriate interventions and notifications will be made based on these reviews. The Director of Nursing, RCMD, and/or Staff Development Coordinator will review 24-hour reports daily, Monday through Friday, to identify any change in resident's condition. Additionally, the licensed nurses will be educated annually on nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 25 include the Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator, Resident Care Management Director, and MDS Coordinator) will meet monthly or as needed. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Residents who exhibit acute changes in condition requiring intervention, such as constipation, have the potential to be affected by the alleged deficient practice. On July 7, 2011, the Director of Nursing began a review of the current residents who have had an acute change in condition requiring notification. On July 7, 2011, the Director of Nursing audited the corresponding documentation in the medical records of these residents to determine that a nursing assessment was done and interventions were implemented, and communicated to the appropriate parties. Two residents were noted with skin tears and the interventions were as follows: treatment initiated, MD and RP notification, identification of the underlying cause with correction. Appropriate notification and treatments initiated and completed for both residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: On July 7, 2011, facility initiated reinforcement of the facility's practice for the Interdisciplinary Team (including the Director of Nursing, Administrator,	F 309	timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition to ensure continued compliance. 4. Quality Assessment and Assurance On July 7, 2011, the Quality Assessment and Assurance Committee, including the facility Administrator, Human Resources Coordinator, Director of Nursing, Resident Care Management Director, MDS Coordinator, Maintenance Director, Social Worker, Activities Director, Therapy Program Manager, Medical Records Coordinator, and Dietary Manager to discuss the acute episode experienced by Resident #1 on December 4, 2011. The Committee also has reviewed this acute episode with the facility's Medical Director. On July 7, 2011, the Committee has reviewed the education materials	

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F 309	Continued From page 26 Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Resident Care Management Director, and MDS Coordinator) to review on a daily basis, Monday through Friday, those residents who have exhibited acute changes in condition to assure that assessments or observations of symptoms are documented, interventions were initiated, and the attending physician was contacted as appropriate by reviewing the 24 hour reports, change of condition forms, Bowel records, and telephone orders. Adjustments to the plan of care and Care Assignment Sheets will be made based on these reviews and the input of medical professionals. On July 7, 2011, the facility initiated a mechanism to account for weekend review of the 24-hour report, incidents and changes in condition by the manager on duty and/or charge nurse. The Director of Nursing or Administrator will be called to discuss findings and initiate further action as appropriate. The Quality Assessment and Assurance Committee will monitor the process daily Monday thru Friday for a period of 4 weeks, then weekly for a period of 4 weeks, then randomly as deemed necessary by the Quality Assessment and Assurance Committee. On July 7, 2011, the Regional Clinical Director, the Director of Nursing, and the Staff Development Coordinator conducted training with all scheduled licensed nurses regarding what constitutes a nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute	F 309	provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. The Administrator and/or Director of Nursing will review data obtained during reviews and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. F 318 1. Resident identified to be affected by the alleged deficient practice.	

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F 309	Continued From page 27 changes in resident condition. The Interact II tool is used for the identification of change in condition, communication of those changes and continuity of care. The Director of Nursing, Resident Care Management Director, or Staff Development Coordinator will provide all licensed nursing staff education prior to being allowed to work. This education will be included in the facility's new hire orientation. Beginning July 7, 2011, scheduled Certified Nursing Assistants were educated regarding notification of the Nurse when a resident experiences a change in condition, including but not limited to constipation, nausea, and vomiting. Certified Nursing Assistants will be provided this education via the Director of Nursing, Resident Care Management Director, or Staff Development Coordinator prior to being allowed to work. In addition, on July 7, 2011 the facility's grand rounds process, which includes Director of Nursing, Resident Care Management Director and/or Staff Development Coordinator, increased the frequency of the grand rounds to at least three times per week for the next four weeks to include observations, discussion with four randomly chosen licensed nurses regarding residents with the potential to have acute changes in condition, identified residents with acute changes in condition, physician involvement as appropriate, and interventions being implemented to address the resident's need. The Director of Nursing and Regional Clinical Director conducted grand rounds on July 7, 2011. Residents were reviewed to assess for additional needs and interventions. The Director of Nursing and Regional Clinical Director also reviewed the documentation in the medical	F 309	Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	

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F 309	Continued From page 28 records of these residents to ensure identification of acute changes of condition and notification of physician. Necessary follow-up was completed and there are no outstanding concerns. Additional measures put into place to ensure the alleged deficient practice does not recur include: The Interdisciplinary Team (IDT) will review bowel reports on a daily basis Monday through Friday during the IDT meeting to ensure any change in condition is identified. Appropriate interventions and notifications will be made based on these reviews. The Director of Nursing, RCMD, and/or Staff Development Coordinator will review 24-hour reports daily, Monday through Friday, to identify any change in resident's condition. Additionally, the licensed nurses will be educated annually on nursing assessment, post-change of condition assessment, use of Interact II tools as guidelines for assessment components, and timely intervention including calling 911 if initial assessment indicates a life threatening event and physician involvement for identified acute changes in resident condition to ensure continued compliance. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility: On July 7, 2011, the Quality Assessment and Assurance Committee (QA&A), including the facility Administrator, Human Resources Coordinator, Director of Nursing, Resident Care	F 309		

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F 309	Continued From page 29 Management Director, MDS(Minimum Data Set) Coordinator, Maintenance Director, Social Worker, Activities Director, Therapy Program Manager, Medical Records Coordinator, and Dietary Manager to discuss the acute episode experienced by Resident #1 on December 4, 2011. The Committee also has reviewed this acute episode with the facility's Medical Director. On July 7, 2011, the Committee has reviewed the education materials provided to the licensed nursing staff regarding identification of change in condition, nursing assessment, and initiation of interventions based on assessment findings. The Administrator and/or Director of Nursing will review data obtained during reviews and report patterns/trends to the QA&A Committee weekly for four weeks and monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance. Immediate Jeopardy was removed on 07/07/2011 at 6:39 PM. Interviews with licensed nursing staff confirmed they had received in-servicing on nursing assessment, use of InterAct II tools as guideline for assessment and when/ whom to notify for acute changes in resident condition. Documentation was provided by the facility that in-servicing began on 07/07/2011 and copies were provided of the tools that would be used as a guideline for assessment.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		

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F 318	Continued From page 30 resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to provide the restorative services for range of motion and strengthening exercises as recommended by the rehabilitation department for 1 of 9 sampled residents reviewed. (Resident #10). Findings included: 1. Resident #10 was admitted to the facility on 1/28/10 with diagnoses which included: diabetes mellitus, osteoporosis, osteoarthritis, chronic ischemic heart disease, hypertension, and, fractured femur. The review of the most recent quarterly MDS (Minimum Data Set) dated 4/11/11 indicated Resident #10 had short and long term memory problems with moderately impaired decision-making skills; required extensive assistance of one person with bed mobility and transfers; was on a toileting program; and, used a wheelchair for mobility. The MDS also indicated the resident was only able to maintain her balance with human assistance; but, had no range of motion impairments.	F 318	1. Resident identified to be affected by the alleged deficient practice. 7-27-11 Resident #10 began treatments in the Restorative Program on 6/7/11. 2. Residents with the potential to be affected by the alleged deficient practice. An audit was conducted of residents who were discharged from the therapy program and referred to the Restorative Program for the past 3 months and completed on 7/25/11. Any residents who were referred to Restorative but had not had restorative services begun were re-screened by therapy and placed in the appropriate restorative programs. 3. Systemic Measures The therapy department is now keeping a written record of when residents are referred to restorative, when the RCAs are trained specific to that resident and when the paperwork is received. The restorative aides are recording when referrals are received and discussing this with the Restorative Nurse Coordinator as referrals are received. The therapy department is conducting an	

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F 318	Continued From page 31 The review of the facility's Fall Risk Evaluation dated 4/8/11 revealed Resident #10 had a score of 10 indicating the resident was at high risk for falls. A review of the Care Plan dated 4/12/11 included as approaches: Resident #10 was on the facility's Falling Star Program; received Physical Therapy; had a bed and chair alarm; and was toileted frequently. The review of the clinical records revealed Resident #10 received PT (Physical Therapy) from 4/19/11 to 4/25/11 for muscle weakness and difficulty walking. The Weekly PT Progress and Update Summary dated 4/25/11 indicated Resident #10 was discharged from therapy services, but was to continue with a Restorative Exercise program beginning 4/26/11. The review of the "Rehab to Restorative Transition Record" dated 4/25/11 revealed PT referred Resident #10 to Restorative Nursing for daily exercise and standing to increase the resident's strength and flexibility. The resident was to receive the restorative nursing six times each week for twelve weeks. The record was signed by the PTA (Physical Therapy Assistant) and RNA#1 (Restorative Nursing Assistant) indicating RNA#1 received the caregiver's training in the functional maintenance program. There was no documentation available indicating Resident #10 received Restorative Nursing from 4/26/11 through 6/6/11.	F 318	ongoing audit of residents referred to the restorative program to insure that services are begun in a timely manner. 4. Quality Assessment and Assurance The therapy manager will include results of the monitor of referrals to restorative in their monthly report to the QA&A Committee monthly for 3 months, then as indicated.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345241	A. BUILDING _____ B. WING _____	07/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 32 A review of the clinical records revealed Resident #10 had an unobserved fall on 5/10/11 while attempting an unassisted transfer from her bed. Interventions included changing the bed alarm to a voice recorded alarm system. The Rehabilitation/Restorative Service Delivery Records (June 7, 2011 through July 6, 2011) revealed Resident #10 received sit to stand; standing knee bends; and range of motion exercises to both lower extremities. During an observation on 7/5/11 at 3:55pm, Resident #10 was observed in her room in a wheelchair with an alarm attached. The resident was alert and revealed that she was not feeling well. During an interview on 7/6/11 at 3:35pm, the Acting DON (Director of Nursing) described the process for referrals to Restorative Nursing as: the Rehabilitative Department would give a copy of the written request for Restorative (Transition Record) to the ADON (Assistant Director of Nursing) and a copy the RNA. The RNA would record the date the request for restorative was received at the top of her copy. The Acting DON stated that in reference to the start date of the restorative for Resident #10, RNA#1 dated the Transition Form on 6/7/11 indicating that date as the date the therapist provided training to her. During an interview on 7/6/11 at 3:40pm, the PTA (Physical Therapist Assistant) revealed Resident #10 was discharged from PT on 4/25/11 and restorative was requested for the resident to begin on 4/26/11. The PTA also revealed that the signatures at the bottom of form indicated training	F 318		

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F 318	Continued From page 33 was provided to the restorative aide on the outlined program. The PTA stated that he did not know why the resident did not receive restorative until 6/7/11. During an interview on 7/7/11 at 2:20pm, RNA#1 revealed Resident #10 began restorative on 6/7/11 for range of motion for bilateral lower extremities and stand to sit exercises; also, knee bends whenever possible. RNA#1 stated she did not remember receiving the Care Provider training from the Rehabilitative Department in April 2011; but confirmed it was her signature on the "Rehab To Restorative Transition Record" indicating she received care provider training. RNA#1 revealed she received the "Rehab Restorative Transition Record" from the ADON and that was when she wrote the date of 6/7/11 at the top of the form.	F 318		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to securely affix handrails in 2 of 5 Halls (300 and 400 Halls). In review of the facility layout, the main dining room was located at the end of the 100 Hall furthest from resident rooms. The 100 and 300 Halls were the main halls leading to the dining room from all resident rooms.	F 468		

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F 468	Continued From page 34 On 07/05/11 at 10:18 AM, while on tour of the facility, handrails on the wall in the 400 Hall outside resident room 406 and in the 300 Hall outside the staff break room were observed to be loose. On 07/05/11 at 11:30 AM, residents in wheel chairs were observed using the handrails in the 100 and 300 Halls to pull themselves on their way to the dining room. On 07/06/11 at 1:12 PM, residents in wheel chairs were observed using the handrails in the 100 and 300 Halls to pull themselves on their way from the dining room. On 07/06/11 at 3:19 PM, the 400 Hall rail outside resident room 406 was visibly loose and could be pulled away from the wall 1/4th inches. The handrail on the wall in the 300 Hall outside the staff break room was visibly loose and could be pulled away from the wall 1/4th inches. The handrail on the wall in the 300 Hall outside resident room 305 was loose and the wall panel and rail had pulled away from the wall 1/4th inches in two areas where the rail had been bolted to the panel and wall. The handrail on the wall in the 300 Hall between the beauty shop and the 400 Hall was visibly loose and could be pulled away from the wall 1/4th inches. On 07/07/11 at 3:46 PM, while on tour with the Acting Director of Nursing and the Maintenance Manager (MM), the MM stated the hand rail in the hall outside resident room 406 was loose and not fixed well to the wall. The MM stated the hand rails in the 300 Hall outside resident room 305, near the beauty shop and the break rooms were	F 468	1. Areas identified to be affected by the alleged deficient practice. The handrail outside room 406, the rail outside the break room, the rail outside room 305, and the rail on 300 hall between the beauty shop and 400 hall have been attached to the wall so that they can not be pulled away from the wall. 2. Residents with the potential to be affected by the alleged deficient practice. Handrails throughout the 5 corridors of the building have been tested and any loose areas have been reattached as necessary. 3. Systemic Measures Handrail security has been added to the maintenance department preventive maintenance program. Handrails will be checked monthly for 3 months, then as indicated. 4. Quality Assessment and Assurance Preparation and/or execution of this plan 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 because it is required by the provisions of Federal and State law.	7-27-11

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F 468	Continued From page 35 loose and not fixed well to the wall. The MM stated the 300 Hall was a high traffic hall for residents.	F 468	The maintenance supervisor will report to the Safety Committee monthly for 3 months, then as indicated.	

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