

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

DEC 16 2011

PRINTED: 12/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345394	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/21/2011
NAME OF PROVIDER OR SUPPLIER BROOK STONE LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573	
(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 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that 1 of 2 residents (# 1) was free from a restraint without a physicians order. The findings include:</p> <p>Resident #1 was admitted to the facility on 10/03/11 with cumulative diagnoses that included Psychotic Disorder, Alzheimer's Disease , and Vascular Dementia. The resident was coded on the most recent MDS (minimum data set) dated 10/18/11 as being severely impaired cognitively. In addition the resident was coded as requiring extensive assist with all ADL's (activities of daily living) and as requiring a trunk restraint. Review of the CAA's (Care Area Assessments) dated 10/12/2011 indicated the resident required a restraint due to his cognitive impairment. Care Plan dated 10/12/2011 indicated the problem area as potential for injury from the Geri-chair with lap tray while out of bed. Interventions included explaining the use of the restraint to the resident, activities to provide program where restraint free time can be provided, review the continued need for the chair at least every quarter and document the findings. A note written on the care plan date 10/20/2011 indicated the resident failed a restraint reduction and the resident was returned to the Geri-chair with the lap tray.</p>	F 221	<p>F 253</p> <ol style="list-style-type: none"> The facility has ensured geri-chair is in proper working order. In-service staff on to reporting, contacting, and communicating with Maintenance Director for repairs of equipment. MDS Nurse, DON, RN Supervisor, & Administrator will monitor for 3 months for potential equipment in need of repairs. Monthly reviews will be discussed monthly during the QA meeting. The Administrator & Social Worker and DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. 	<p>12-14-11</p> <p>12-19-11</p> <p>12-19-11</p> <p>12-19-11</p>

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

TITLE

(X8) DATE

[Signature]

Administrator

12-14-11

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 221	<p>Continued From page 1</p> <p>Upon admission the resident was identified as being at risk for falls. The resident was assessed for the use of a restraint. A physician order was obtained for the Geri-chair. The resident did have a restraint reduction attempted on 10/19/2011 to a tilt wheel chair with personal alarm. According to the documentation, the restraint reduction failed. Review of the medical record revealed a physicians order dated 10/20/2011 that read " Geri-chair with lap tray when out of bed, remove lap tray with 1:1 supervision".</p> <p>The resident was observed on 11/20/11 at 2:14 pm sitting in a Geri-chair with the lap tray, with a helmet on and a white sheet tied around his waist and the chair. The foot rest of the chair was up, the resident did not speak. He was moving around, pushing on the Geri-chair tray. The resident kept pushing on the Geri chair tray, moving his feet on and off the footrest.</p> <p>Interview on 11/20/2011 at 2:34 pm with NA #1 indicated she did not place the sheet to the resident and indicated it was done by a nurse.</p> <p>Interview on 11/20/2011 at 2:37 pm nurse #1 indicated that the resident's Geri-chair was noted to be broken on 11/19/2011. Nurse #1 indicated she can put a work order in but nothing would be fixed until Monday morning. Nurse #1 indicated the resident was found wandering in another resident room today. She stated she did not place the sheet to the Geri chair. Nurse #1 indicated the resident stands a lot and attempts to pull the Geri-tray up and it did not unlatch today. Nurse #1 indicated the resident does have a personal alarm to his bed, not the Geri chair.</p>	F 221			

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F 221	Continued From page 2 Interview on 11/20/2011 at 2:41 pm with Nursing Supervisor indicated the Geri-chair tray was fixed an hour ago (1:40 PM). She indicated she placed the sheet to the resident and his Geri-chair around 11:00 am. She indicated the resident was at the nurse's station throughout the day and was just brought back to his room to be checked to make sure the resident was clean and dry. The Nurse Supervisor indicated she did not know if a sheet was an acceptable restraint at this facility or if she needed a physicians order. She indicated the sheet had been placed on the resident and removed frequently throughout the day. The Nursing Supervisor further stated it had "only been used today not yesterday". She indicated she did not know when the chair broke. She indicated the resident was able "to move the tray all over today". The Nurse Supervisor indicated that the maintenance person had been in the facility earlier that day as the administrative person, but that he was not notified about the chair because they had fixed it. Interview with Nurse #2 indicated she earlier in the day had manipulated (fixed) the Geri-chair tray latch to prevent the resident from removing the lap tray. She indicated with the residents constant pulling on the lap tray the latch had broken again. Nurse #2 indicated there was no other Geri-chair to place the resident in. Interview on 11/20/2011 at 3:22 pm with the Director of Nursing (DON) indicated her expectations were that if a resident was agitated the nurse would asses the resident for pain, hunger and to look in the resident medical record for disease processes that could explain the	F 221			

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F 221	Continued From page 3 behavior. She indicated she would expect the nurse to call the physician and report the situation and to obtain orders. She indicated the physician usually would order as needed medications, or if there was severe agitation would send the resident to the emergency room for evaluation. She indicated that if resident #1 had previously been medicated she would expect the staff to call the physician. She indicated her expectation would be for the staff not to use a sheet and would have expected the staff to call the maintenance personal to report a broken chair. She further stated that if a resident required a restraint, that the physician would be notified and that orders for the restraint would be gotten. Interview on 11/20/2011 with the Administrator indicated she would have expected the staff to call the maintenance personal because he would have told them what other chairs would have been available and he would have informed her. Interview on the 11/21/2011 at 9:25 am with the Maintenance Director indicated he observed the named resident on 11/20/2011 at about 9:30 am at the nursing station pulling up on the Geri-chair tray. He indicated the tray did not come loose. He indicated he keeps a log book with work order request. Review of the log book did not indicate any issue with resident #1 Geri-chair.	F 221			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			

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F 253	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that the Geri chair for 1 of 2 (#1) residents was in working condition. The findings include:</p> <p>1. Resident #1 was admitted to the facility on 10/03/11 with cumulative diagnoses that included Psychotic Disorder, Alzheimer's Disease and Vascular Dementia. The resident was coded on the most recent MDS (minimum data set) dated 10/18/11 as being severely impaired cognitively. The resident was observed on 11/20/11 at 2:30 PM sitting in a Geri chair in his room. There was a lap tray attached to the chair. The resident appeared confused, did not respond verbally and was sitting pulling on the lap tray. After a few pulls the lap tray would separate from the Geri chair on the left side.</p> <p>During an interview with the Nursing Supervisor on 11/20/11 at 2:41 PM. it was revealed "the lap tray was broken earlier but we were able to fix it. Now he keeps pulling on it and it comes apart." The Nursing Supervisor indicated that the Maintenance person had been in the facility earlier in the day as the Administrative person, but that he was not notified of the chair because they had fixed it.</p> <p>During an interview with the Administrator on 11/20/11 at 3:22 PM it was revealed " I would have expected the staff to call the Maintenance person about the chair."</p> <p>During an interviews with the Maintenance Director on 11/21/11 at 9:30 AM it was revealed</p>	F 253	<p>F 221</p> <p>1. A physician's order was obtained for a soft non-release restraint for Resident #1.</p> <p>2. Resident's with restraint(s) or in need of restraint(s) were audited to ensure physician's orders are in place. Staff in-serviced on obtaining physician orders for use of restraint(s), assessing Resident's condition, contacting physician to report situation and follow orders as given.</p> <p>3. MDS Nurse, Floor Nurse, RN Supervisor, will monitor weekly for 3 weeks and then periodically to determine physician orders are in place for the use of restraints, if needed.</p> <p>4. Monthly reviews will be discussed monthly during the QA meeting. The MDS Nurse and DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months.</p>	<p>12-19-11</p> <p>12-19-11</p> <p>12-19-11</p> <p>12-19-11</p>	

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F 253	Continued From page 5 "I walk the halls every day to see if there is anything broken or in need of repair. If something is not working, the staff makes out a work order. They are at the nursing station desk. They put them in a basket at the desk and I look for them everyday. I keep a log in my office of what is in need of repair. I was on Administrative duty this morning and (name of resident) was sitting in the chair and it was not broken. (Name of Nurse Supervisor) told me that it broke around 11:00AM. I left around 10:30 or so. If something was wrong I would have looked at it while I was here." A review of the maintenance log did not reveal any work order for the Geri chair.	F 253			

**Brook Stone Living Center
P.O. Box 429
Pollocksville, NC 28573
Phone: 252-224-0112 Fax: 252-224-1076**

December 14, 2011

**NC Department of Health and Human Services
Division of Facility Services
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711**

Dear Ms. Pinto:

Enclosed you will find our plan of correction for the complaint investigation survey conducted in our facility from 12/20/11 to 12/21/11.

If you need further information, please contact me at the above number.

Sincerely,

A handwritten signature in cursive script, appearing to read "Janice Mallard".

**Janice Mallard
Administrator**