STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVE MOORESVILLE, NC 28115

(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 157 SS=D	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 staff interviews and record review the facility failed to notify the Physician of significant	F 157	F 157 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #109 by providing and documenting notification to the attending physician of the noted weight losses. Upon notification, The Director of Nursing provided training to LN #3 regarding on Notification of Physicians for significant weight loss. 2. Facility residents requiring daily monitoring of weights have the potential to be affected by this same alleged deficient practice; therefore, the Director of Nursing, Unit Coordinators and/or Staff Development Director will completed an audit of current residents requiring this level of monitoring to ensure physician notification and documentation. Any negative findings will be immediately corrected. This audit will be completed on or before 6-7-12. Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	6.7.12

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

Administrator | 5.28.12

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.

RECEIVED
MAY 30 2012
BY: NRH

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F 157	Continued From page 1 weight changes in a resident being monitored for congestive heart failure for one (1) of three (3) sampled residents (Resident #109). The findings are: Resident #109 was admitted to the facility on 1/6/12 diagnosed with hypertension, congestive heart failure (CHF) and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) dated 1/13/12 specified the resident had no cognitive impairment and was not on a diuretic medication. Review of Resident #109's medical record revealed a Physician's order dated 1/17/12 that specified the resident was to receive 80mg (milligrams) of Lasix (diuretic medication) daily. A second Physician's order dated 1/19/12 specified the resident was to be weighed every Monday, Wednesday and Friday and to notify the Physician if the resident experienced a three (3) pound weight change. Further review of Resident #109's medical record revealed her weights were: 1/20/12 220.3 pounds (lbs) 1/23/12 195.0lbs (-25.3lbs) 1/25/12 215.2lbs (+20.2lbs) 1/30/12 214.8lbs 2/1/12 213.6lbs 2/3/12 211.0lbs 2/6/12 200.2lbs (-10.8lbs) 2/8/12 193.0lbs (-7.2lbs) 2/10/12 195.4lbs 2/12/12 189.4lbs (-6.0lbs)	F 157	3. Measures put into place to ensure that the alleged deficient practice does not recur include: In-services for licensed nursing staff by the Staff Development Coordinator or Director of Nursing regarding the notification of physician's for weight loss and the documentation of notification. Resident's requiring daily monitoring of weights will be reviewed by the IDT three times (3X) per week for 3 weeks to ensure notification per physician guidelines. Thereafter, new weights will be reviewed weekly for 3 weeks and monthly for 3 months. Negative Findings will be correctly. 4. The Director of Nursing and/ or Administrator will maintain the results of the IDT Meeting in a secure location and on a monthly basis, analyze the data for trends/patterns. The Director of Nursing and/or Administrator will report the findings to the QA/PI Committee. Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	6.7.12

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F 157	Continued From page 2 In reviewing the medical record there was no documented evidence the Physician was notified on 1/23/12, 1/25/12, 2/6/12, 2/8/12 and 2/12/12 of the resident's significant weight change. On 5/9/12 at 11:30 a.m. licensed nurse (LN) #2 was interviewed. She reviewed Resident #109's Medication Administration Record (MAR) and reported the resident was scheduled to be weighed three times a week and a change of -+ 3 pounds was to be reported to the Physician. She stated that she was trained to either call the Physician with a significant change in status or to fax the Physician a form titled "Change in Condition." She added a "Change in Condition" form would be kept in the medical record. On 5/10/12 at 10:30 a.m. the LN (LN #3) assigned to care for Resident #109 on 2/6/12 was interviewed. LN #3 reported Resident #109 had an order to notify the Physician if her weight status changed + 3 pounds. She added that she was trained to notify the Physician by either calling or faxing a "Change in Condition" form to the doctor. Resident #109's 2/12 MAR was reviewed with LN #3 that specified on 2/6/12 the resident experienced a -10.8lb change in her weight status. LN #3 confirmed the Physician should have been notified. LN #3 stated that she could not remember if she notified the Physician of the significant change in the resident's status but that if she had it would have been documented either in the nurses' notes or on a "Change in Condition" form. On 5/10/12 at 10:45 a.m. the Director of Nursing (DON) reviewed Resident #109's weights documented on the MARs and confirmed there	F 157	Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	6.7.12

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F 157	Continued From page 3 was no documentation that the Physician was notified of the weight changes on 1/23/12, 1/25/12, 2/6/12, 2/8/12 and 2/12/12. She reported that ideally the nurse should document in the nurses' note or on a "Change in Condition" form when they notified the Physician. On 5/10/12 at 2:15 p.m. the Physician was interviewed and reported Resident #109 was started on Lasix related to CHF and was a resident that he expected licensed nurses to monitor. He added that he expected to be notified of changes in condition with the resident including + 3 pound weight change. The Physician was unable to recall if he was notified on 1/23/12, 1/25/12, 2/6/12, 2/8/12 or 2/12/12 of the resident's significant weight change. He credited the facility by saying he thought they likely did notify him just failed to document the notification.	F 157		6.7.12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to follow a Physician's order for obtaining blood pressure (BP) when administering a blood pressure medication and failed to clarify a Physician's order for blood pressure monitoring for one (1) of ten (10) sampled residents reviewed for unnecessary medications (Resident #109).	F 281	F281 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #109 by clarifying the Physician order regarding obtaining blood pressure and administration of blood pressure medication. Upon notification, the Director of Nursing Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	

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F 281	Continued From page 4 The findings are: Resident #109 was admitted to the facility on 1/6/12 and re-admitted on 3/23/12 diagnosed with hypertension, congestive heart failure and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) dated 1/13/12 specified the resident had no cognitive impairment and received oxygen therapy. Review of Resident #109's medical record revealed Physician ordered changes made to the resident's antihypertensive medications that included decreasing Coreg (an antihypertensive medication). On 3/23/12 her re-admission orders specified she was to receive Coreg (antihypertensive medication) twice daily with blood pressure readings. On 5/8/12 at 12:00 p.m. Resident #109 was interviewed and reported that her BP was taken weekly and occasionally more often. a. Further review of the medical record revealed a document titled "Medication Administration Record" (MAR) dated 4/12 that specified Resident #109's BP was documented as having been done ten (10) out of sixty (60) times. The blood pressure readings documented were within normal limits for the resident. Resident #109's MAR for 5/12 was also reviewed and revealed that on 5/10/12 the resident had received her Coreg and no BP was documented. On 5/10/12 at 1:45 p.m. the Director of Nursing (DON) was interviewed and reviewed Resident #109's MARs and confirmed the resident's BP	F 281	completed an assessment of the resident and provided the results of that assessment to the attending physician. NO negative findings noted by the physician. Upon notification, The Director of Nursing provided training to LN #1 regarding obtaining blood pressures in accordance with the physician order. 2. Facility residents with medication that require monitoring of blood pressure have the potential to be affected by this alleged deficient practice; therefore, the Director of Nursing, Unit Coordinator and/ or Staff Development Coordinator will completed an audit to identify all residents on medications requiring the monitoring of blood pressure and ensure documentation of blood pressure per physician orders. Audit will be completed on or before 6-7-12. 3. Measures put in place to ensure that the same alleged deficient practice does not recur include: In-services for licensed nursing staff by the Staff Development Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	6.7.12

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F 281	Continued From page 5 was not documented as having been done. She stated that she would expect the licensed nurses to follow Physician's orders as written. Licensed nurse (LN) #1 was interviewed on 5/10/12 at 2:20 p.m. and reported she had given the resident her Coreg without taking the resident's BP. She stated it was an error on her part and that she routinely administered the Coreg without taking the resident's BP. She stated she was trained to follow Physician's orders as written and failed to do so when she did not take Resident #109's BP when she administered the Coreg during her morning medication pass. b. Further review of the medical record revealed a document titled "Medication Administration Record" (MAR) dated 4/12 that specified Resident #109's BP was documented as having been done ten (10) out of sixty (60) times. The blood pressure readings documented were within normal limits for the resident. On 5/10/12 at 1:45 p.m. the Director of Nursing (DON) was interviewed and reviewed Resident #109's MARs and confirmed the resident's BP was not documented as having been done. She stated that she would expect the licensed nurses to contact the Physician to clarify an order that was in question. Licensed nurse (LN) #1 was interviewed on 5/10/12 at 2:20 p.m. and reported she had given the resident her Coreg without taking the resident's BP. She stated it was an error on her part and that she routinely administered the Coreg without taking the resident's BP. She	F 281	Coordinator or Director of Nursing regarding the monitoring and recording of blood pressures. Resident's with medications that require blood pressure monitoring, results/documentation will be reviewed by the IDT three times (3X) per week for 3 weeks to ensure physician order is followed. Thereafter, blood pressures will be reviewed weekly for 3 weeks and monthly for 3 months. Negative Findings will be correctly. 4. The Director of Nursing and/ or Administrator will maintain the results of the IDT meetings in a secure location and will review the results of the IDT meeting for patterns and trends and report findings to the QA/PI committee. Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	

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F 281	Continued From page 6 stated that taking a BP with an antihypertensive medication was not always typical and that she felt it was not necessary to take the resident's BP. She added that she was trained to clarify Physician's orders that had discrepancies and that she failed to do so regarding Resident #109's Coreg and BP.	F 281	Preparation and/or execution of this plan of correction 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 solely because it is required by the provisions of federal and state law."	6.7.12