STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345232	A. BUILDING _____ B. WING _____	C 09/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHABI HICK	3031 TATE BLVD SE HICKORY, NC 28602

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID#S1F511.	F 000	This Plan of Correction is the facility's credible allegation of compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interview the facility failed to involve and receive consent from a resident (Resident #176) regarding a change in dialysis time, prior to the time being changed for one (1) of (2) two sampled resident receiving hemodialysis. (Resident #176). The findings include: Resident #176 was admitted on 7/28/11 with diagnoses of End Stage Renal Disease, Hypertension, Diabetes and Asthma. An annual Minimum Data Set (MDS) assessment dated 6/29/12 documented Resident #176 with no cognitive impairment and able to understand and make her self understood. Resident #176 received hemodialysis every Monday, Wednesday and Friday at 6:30AM. Review of a nurse's note dated 8/31/12 read: "	F 242	Corrective Action has been accomplished for Resident #176 related to the alleged deficient practice. Resident #176 was requested to resume her prior dialysis schedule of Monday, Wednesday, and Friday early AM treatment on August 24, 2012. Resident #176 was transitioned to the Monday, Wednesday, and Friday early AM treatment schedule on Friday September 21st, 2012. Resident #176 is currently receiving dialysis treatment at her preferred time. Other residents receiving dialysis treatments have the same potential to be affected by the alleged deficient practice. All current facility residents receiving dialysis services were reviewed and verified that the time of the service is either preferential to the resident, or if changes have been to the initial admitting dialysis schedule, the resident has had prior opportunity to discuss any concerns or hesitations to changes in the dialysis schedule. Presently no other resident in the facility has had any changes in their admitting dialysis schedule. Administrative Nurses inclusive of Director of Nursing, Assistant Director of Nursing, Unit Manager, and Social 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 laws.	

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

Ashley J. Smithey — Administrator — 10/18/12

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.

Original Signature Date: 10-12-12

RECEIVED
OCT 18 2012
BY:

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F 242	Continued From page 1 Late entry for 8/3/12: Dialysis appointment time changed due to an opening at the dialysis center to a time that our staff is able to transport the patient without using outside transportation services. Explained to resident the need to change the appointment time. The Resident states want to continue early appointment. Offered to discuss with the Administrator if she wants to change the time to an earlier and she declined the discussion." Review of a social work progress note dated 8/30/12 documented a follow up conversation on 8/24/12 regarding Resident # 176's change in dialysis time. The note recorded the Resident was told she was still on the waiting list at Dialysis for her old scheduled time. The note further documented the responsible party was contacted on 8/24/12 regarding the Resident being on a waiting list right now for her old dialysis scheduled time. During an interview with Resident #176 on 9/18/12 at 5:52 PM, Resident #176 revealed her dialysis time had been changed a little over a month ago and that she had never been asked about the change in time. She continued to explain the nurse manager notified her that her dialysis time was changed from 6:00 AM to11:00 AM. She further added the facility did not ask her if it would be agreeable with her to change her dialysis time. During an interview with Nurse #4 on 9/19/12 at 1:08 PM, Nurse #4 stated Resident #176's dialysis time was changed to enable the Resident to be transported by the facility van. Nurse #4 further explained she notified the Resident after	F 242	Workers received education on October 10, 2012, on the facility Transportation Procedure and residents right to make choices about aspects of his or her life in the facility that are significant to the resident. Administrator will maintain a master log of all residents admitted with dialysis and what their admitting schedule is for dialysis treatment. Upon any changes, or discussion of potential change in dialysis schedule, documentation will be posted to the medical record and log sheet of the dates of the discussions with resident and/or responsible party, indication for change, notification of resident and/or responsible party of change, and date of anticipated change if all involved parties are in agreeance. All discussions will be performed with the resident and/or responsible party prior to any commenced change in schedule. Administrator will report to Quality Assurance and Performance Improvement with identified trends or patterns. The identified trends or patterns will be reported to the Quality Assurance and Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan 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 laws.	

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

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F 242	Continued From page 2 her dialysis time had been changed. She continued to explain when she told the Resident about the changes in dialysis time Resident #176 stated she wanted to continue with the old scheduled dialysis time. Nurse #4 informed the Resident she would have to speak with the Administrator and Nurse #4 said the Resident told her that she would. Nurse #4 stated she did not ask Resident #176 if the time would be acceptable to her. During a telephone interview with a Nurse from the Dialysis center on 9/19/12 at 2:25 PM, the Nurse revealed the facility called and changed the dialysis times due to not being able to provide transportation at the original dialysis time. The Nurse further explained the facility called her and asked if the Dialysis center could change Resident #176 from her 6:30 AM time to an 11:30 AM time and told her that the Resident had been informed. The Nurse continued to say when the Resident arrived for her next Dialysis treatment at the 11:30 AM time on 8/6/12 she was upset because she did not want her time to be changed. The facility called the Center on 8/24/12 asking if the center could place the Resident back at the 6:30 AM time slot and there was no availability so Resident #176 was placed on a waiting list. An interview with the social worker (SW) on 9/19/12 at 12:24 PM revealed that Resident #176 had complained to her about the change in Dialysis times on 8/24/12. She added the Resident was concerned because the new time did not allow her family to visit with her on dialysis days. The SW further added Resident # 176's family visited very often, even on dialysis days.	F 242	based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation and monitoring of dialysis schedules will occur with additional staff education. Date of Completion: October 19, 2012 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 laws.	10/19/12

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F 242	Continued From page 3 The SW also stated she forwarded this concern to the Administrator. An interview with the Administrator on 9/19/12 at 3:35 PM revealed Resident #176 had received dialysis services since admission in 2011 and the facility had provided outside transportation up until August 3, 2012. The Administrator stated the Resident's schedule was changed to facilitate the schedule of the facility van drivers. She further added the Dialysis center was contacted and the times were changed prior to Resident #176 being notified. The Administrator further explained Resident #176 was notified by the nurse on the day the Dialysis time was changed and was informed she would have to cover the cost of transportation to dialysis if she wanted to continue with her 6:30AM dialysis time. The Administrator added she became aware on 8/15/12 that Resident #176 was not pleased with the change in time. The Administrator stated she did not have a conversation with Resident #176 prior to the change in dialysis time and she did not ask her if the time change would be acceptable. An interview with the Assistant Director of Nursing (ADON) on 9/19/12 at 4:17 PM revealed Resident #176's dialysis times were changed because the specialty transport was very expensive and the facility wanted to use its own transportation to cut down the cost. The ADON further explained she called the dialysis center and changed the time and she did not have a conversation with the Resident regarding whether the time change would be acceptable or not. During an interview with the Director of Nursing (DON) on 9/19/12 at 4:30 PM, the DON revealed	F 242	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 laws.	

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F 242	Continued From page 4 she would have expected someone to have communicated with Resident #176 prior to changing her dialysis time. The DON further added that when an earlier time was available at the dialysis center Resident #176 should have been consulted and some type of agreement reached between the Resident and the facility. An interview with Resident #176 was conducted on 9/19/12 at 5:17 PM; Resident #176 stated the change in her dialysis time really hurt her because it prevented her family from visiting with her on dialysis days. The Resident added before the change in dialysis time she saw her family everyday and 3-4 hours on dialysis days, however now on dialysis days she did not see any of her family.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide activities of interests for one (1) of three (3) sampled residents. (Residents #85) The findings include: Resident #85 was admitted 4/30/07 with diagnoses of End Stage Dementia, Anxiety and	F 248	Corrective action has been accomplished for the alleged deficient practice for Resident #85. Resident #85 has and will continue to attend, and be provided the opportunity to engage in activities of interest. The care plan for Resident #85 indicates a goal to attend activities of interest either in resident room or group setting and have documentation of attendance or completion of leisure activities. All other facility residents have the potential to be affected by the same alleged deficient practice. Each resident within the facility will be provided activity 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 laws.	

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F 248	Continued From page 5 Hypertension. An annual Minimum Data Set (MDS) assessment dated 12/22/11 indicated the Resident had severe cognitive impairment and preferred to listen to music and enjoyed snacks. The most recent Activity Assessment/ History dated 2/2/10 documented Resident #85's activity pursuit patterns of current interest were music, talking, conversing and spiritual/religious activities. Resident #85's activity progress note dated 6/12/12 noted he was fed by staff; activity remained the same; he was assisted to musical and spiritual activities programs, reading, parties and socials. The note indicated the Resident was out of bed daily to Geri chair where he sat outside the nurse's station and clapped hands or rubbed hands briskly. Review of an activity note dated 8/30/12 documented no change in active participation. The Resident was documented as a passive participant in spiritual religious activities, reading programs and active parties and social. The note further noted Resident to be nonverbal and unable to make his needs known. A plan of care dated 9/16/12 with a problem documented Resident #85 was unable to make his needs known and needed assistance to and from activity locations. The Goal was to be involved in at least one activity of interest per day while in room as evident by: watching television (TV); reading and /or visiting with family or friends and attending 1-2 programs weekly. The interventions included: recording independent leisure pursuits in activity attendance record;	F 248	programming consistent with his or her individual interests and in accordance with their individualized plan of care. A facility Activities calendar will be completed monthly and made accessible to each resident for review for consideration of attendance at scheduled activity programming. Individual activity visits and independent leisure activity will be documented for all residents on their individualized activity attendance record. Independent visits and leisure activities will also be provided in accordance with each resident's interests and care plan goals. Activities staff provided education on October 10, 2012 by the Administrator for the facility, in regards to providing activity programming to meet the needs and interests of all residents. Activities department provided guidance by the Administrator to complete individualized resident documentation of attendance and involvement in activities. Regulatory requirements for Activity programming reviewed by the Administrator with the activity department staff members inclusive of the facility requirement to identify each resident's interests and needs, and to involve the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident's highest 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 laws.	

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F 248	Continued From page 6 provide radio/TV as needed; assist to music, church, friendly visit and provide needed material for resident such as reading material, pens, pencils, paper, and batteries for remote control as needed. Resident #85's room was observed on 9/18/12 at 1:03 PM to have a television and no radio. Resident #85 was observed on 9/18/12 at 11:26 AM and 1:30 PM; on 9/19/12 at 9:45 AM, 11:38 AM and 4:28 PM; on 9/20/12 at 8:48 AM, 9:45 AM, 10:10AM and 1:52 PM and on 9/21/12 at 9:25 AM sitting up in his wheelchair with eyes closed across from the nurse's station. During an interview with nursing assistant (NA) # 1 on 9/20/12 at 8:52 AM, NA #1 explained she provided care for Resident #85 on a regular basis. NA #1 further explained she did not take Resident #85 to activities, she stated the transportation of residents to activities was the responsibility of activity personnel. The NA further explained Resident #85 was legally blind and could not talk. She stated he use to watch television but did not anymore and she was not aware of what his activity preferences were. During an observation on 9/20/12 at 9:03 AM, NA #1 was noted to push Resident #85 from his room in his wheelchair and leave Resident #85 sitting in his wheelchair across from the nurse's station. During an interview with the Activity Director (AD) on 9/20/12 at 9:33 AM, the AD revealed Resident #85 remained in the hallway whenever he was not in a music activity, since she knew music was	F 248	practicable level of physical, mental, and psychosocial well-being. Activities staff will complete individualized resident activity participation logs to ensure that each resident has activity engagement and opportunity for involvement with programming consistent with his or her interests and care plan. Activity staff will develop and provide a monthly activities calendar with programming appropriate for the collective interests of all facility residents, and will provide ancillary activities and materials for residents choosing to engage in independent activities. Activities staff will address with Resident Council monthly the activity programming and solicit recommendations or suggestions for changes. Activity Director will report to Quality Assurance and Performance Improvement with identified trends or patterns. The identified trends or patterns will be reported to the Quality Assurance Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional 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 laws.	

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F 248	Continued From page 7 one of the things he liked and would respond to. She further added that he was not given a radio in his room because he was in the hallway more than in his room. During a follow-up interview with the AD on 9/21/12 at 9:19 AM, the AD explained she would have expected the Activity Assistant to have assisted Resident #85 to attend music, social and spiritual activities. During an interview with the Administrator on 9/21/12 at 1:04 PM, the Administrator stated she would expect the Activity department to provide activities that would engage the residents both actively and passively.	F 248	months of close observation and monitoring of activity attendance and involvement in activity programming consistent with each residents individualized interests will occur with additional staff education. Date of Completion: October 19, 2012	10/19/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and document review the facility failed to keep the inside of the ice machine in the kitchen free from black debris. The findings are:	F 371	Corrective action for the alleged deficient practice has been accomplished and compliance will continue with safe storage, preparation, and distribution of food under sanitary conditions. The identified ice machine was cleaned and sanitized thoroughly on 9/17/12. The ice machine will continue with weekly assigned cleaning as indicated on the Dietary Cleaning log, as well as, intermittent cleanings as necessary. 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 laws.	

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F 371	Continued From page 8 On 09/17/12 at 11:12 AM an initial tour was made of the facility's kitchen with the Dietary Manager (DM) and the Assistant Dietary Manager (ADM). The ice machine used to serve resident's was observed to be approximately one-half full of ice. Located inside the ice machine was a plastic guard and when the guard was lifted there was approximately a two (2) inch wide continuous line of black debris that extended from the front right side of the box, around the entire back of the ice box and along the left side to the front. The top of the ice touched the line of black debris. The DM wiped the black debris off the inside right side wall and the back wall onto her fingers. The DM was interviewed and confirmed the ice machine was full of ice this morning but ice had been removed when it was served to residents and was now only half full. The ADM stated the ice machine was on a routine cleaning schedule for weekly cleaning and produced a cleaning document titled "Weekly/Monthly Cleaning Schedule" that specified the ice machine was last cleaned on 09/10/12. The DM stated she expected dietary staff to clean the ice machine as scheduled and also as needed. During the interview a dishwasher/dietary aide used a scoop to remove ice from the ice machine into a large cooler for distribution of ice to residents. During a follow up interview on 09/17/12 at 4:15 PM the ADM stated she was not sure why the black debris was in the ice machine this morning and it should not have been there. She explained she thoroughly cleaned the inside of the ice machine this morning after she saw the black debris and removed it from both sides and back of the ice machine.	F 371	Dietary department provided education by Dietary Manager on the facility-cleaning schedule inclusive of, as needed cleaning, daily monitoring for sanitation, and sanitation requirements for the ice machine. Staff members of the dietary department will conduct audits a minimum of five times weekly to ensure that the ice machine is of proper sanitation and no debris is evident within the ice machine. Dietary Director to review audit tool to ensure that frequent observations of the sanitation of the ice machine is being completed and that appropriate cleaning or other servicing is being accomplished as identified. Dietary Director to review weekly cleaning logs to ensure that all areas of the dietary department are receiving proper cleaning to maintain safe storage, preparation, and distribution of food items. Dietary Director will report to Quality Assurance and Performance Improvement with identified trends or patterns. The identified trends or patterns will be reported to Quality Assurance and Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan 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 laws.	

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation of routine cleaning schedule and ice machine sanitation will occur with additional staff education. Date of Completion: October 19, 2012 Corrective action has been accomplished in regards to the alleged deficient practice. The undated vial of Tuberculin Purified Protein Derivative has been discarded. The bottle of Sterile Normal Saline that was not dated has been discarded. Any multi-dose liquid or injectible item has the potential to be affected by same alleged deficient practice. These items must be dated at the time opened and first utilized, and stored appropriately. Each item must then be discarded accordingly in regards to manufacture recommendation and facility storage procedure. All Licensed Nurses and Medication Aides have been educated by the Director of Nursing beginning on September 27, 2012 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 laws.	10/19/12

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BRIAN CTR HEALTH & REHABI HICK	3031 TATE BLVD SE HICKORY, NC 28602

(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 431	Continued From page 10 Based on observations, review of facility policy, and staff interviews the facility did not date one (1) vial of Tuberculin Purified Protein Derivative (PPD) when it was opened for use in one (1) of three (3) medication storage refrigerators. The facility also did not date one (1) bottle of Sterile Normal Saline (NS) when opened for use in one (1) of five (5) medication carts. The findings are: 1. A review of a facility document entitled, "LTC Facility's Pharmacy Services and Procedures Manual" , dated May, 2010 stated, "5. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dated for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened". An observation of the East wing medication refrigerator on 09/20/12 at 2:35pm revealed an open, undated vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis). On the side of the bottle the manufacturer indicated once the bottle was opened it was stable for use for thirty (30) days after the date it was opened. An interview with Nurse #2 on 09/20/12 at 2:35pm revealed the vial of Tuberculin PPD should have been labeled with the date it was opened on the outside of the vial. Nurse #2 stated it was the facility's policy to date medication vial when they were opened for use and discard them after thirty (30) days.	F 431	and concluding on October 18, 2012 on facility practice for dating and labeling medications and biological packages once it is opened. Any nurse that could not receive the education prior to October 18, 2012, will receive one to one training with the Director of Nursing prior to assuming work as a medicating nurse on their next assigned shift. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Any newly hired Licensed Nurse or Medication Aide will be provided education by the Director of Nursing or designated Registered Nurse trainer on facility practice for dating and labeling medications and biological packages once it is opened prior to working in the role of a medicating nurse. Administrative Nurses inclusive of Director of Nursing, Assistant Director of Nursing, Unit Manager, and licensed nurses will conduct a minimum of five audits weekly of either medication carts, medication refrigerators, and/or pharmacies to ensure that any opened item has been labeled with the date opened, and is discarded in accordance with the shortened expiration date. Director of Nursing will report to Quality Assurance and Performance Improvement 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 laws.	

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F 431	Continued From page 11 An interview with the Assistant Director of Nursing (ADON) on 09/20/12 at 2:45pm revealed the nurse should have written the date on the vial of Tuberculin PPD when it was opened for use. An interview with the Director of Nursing (DON) on 09/20/12 at 3:55pm revealed she expected nursing staff to write the date on Tuberculin PPD vials when they were opened for use. She stated the facility's policy was to write the date on any medication vial when it was opened so that the vial could be discarded thirty (30) days after the date it was opened. 2. An observation of the East wing medication cart on 09/21/12 at 10:15am revealed an open undated bottle of NS in the bottom drawer. The bottle was two-thirds full. An interview with Nurse #5 on 09/21/12 at 10:15am revealed the bottle of NS should have been dated when it was opened for use and thrown away twenty-four (24) hours after it was opened. An interview with the DON on 09/21/12 at 10:20am revealed she expected staff to write the date on bottles of NS when they were opened for use and discard them twenty-four (24) hours after the date they were opened.	F 431	with identified trends or patterns. The identified trends or patterns will be reported to Quality Assurance and Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation of dating and labeling medications when opened will occur with additional staff education. Date of Completion: October 19, 2012	10/19/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514	Corrective action has been accomplished for Resident #170 in regards to the alleged deficient practice. Resident #170 has been evaluated by skilled therapy services for the institution of skilled therapy after a fall. Skilled therapy services were not indicated at this time upon the completion of the evaluation. 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 laws.	

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F 514	Continued From page 12 standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews facility staff failed to complete an in house communication form to obtain a referral for therapy after a resident fall in one (1) of three (3) residents reviewed for falls. (Resident #170). The facility also failed to include frequency of medication doses on the physician's order sheets for three (3) of ten (10) residents. (Resident #53, Resident #13, and Resident #71). The findings are: 1. Resident #170 was admitted with diagnoses including Alzheimer's disease, pain, anxiety and agitation. The most recent quarterly Minimum Data Set (MDS) dated 09/07/12 indicated Resident #170 had impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS also indicated Resident #170 had behaviors of hitting and kicking and required extensive assistance from staff for transfers, walking and activities of daily	F 514	All residents experiencing falls where an interdisciplinary decision is made to request a therapy evaluation has the potential to be affected by the same deficient practice. It is facility practice to complete an In-House Communication Tool to formally request a therapy evaluation upon the interdisciplinary decision. Administrative Nurses inclusive of the Director of Nursing, Assistant Director of Nursing, Unit Manager, Rehabilitation Program Manager, Therapy department designee, and other members of the Interdisciplinary Team were provided education on October 10, 2012, by the Administrator on completion of facility In House Communication Tool and follow-up to ensure that assessment, evaluation, and possible implementation of treatment has occurred. Director of Nursing to maintain a copy of completed In House Communication Tools upon the decision of the Interdisciplinary Team to request skilled therapy evaluation and intervention. The Rehabilitation Program Manager will provide follow-up to the Director of Nursing upon completion of the evaluation by skilled therapy. Rehabilitation Program Manager or therapy department designee will attend 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 laws.	

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F 514	Continued From page 13 living. The MDS further indicated Resident #170 had two (2) falls with no injury and two (2) falls with injury since the previous assessment. A review of a facility document titled "Change of Condition" dated 09/04/12 indicated Resident #170 had a fall and was confused and restless. The document also indicated to monitor vital signs every shift and the physician and responsible party was notified on 09/04/12 at 3:15 PM. A review of a facility document titled "Interdisciplinary Post Fall Review" dated 09/04/12 indicated Resident #170 was standing in the hallway with her right (R) hand on the handrail and went to a sitting position. The document also indicated Resident #170 had no injury and a recommendation was made for a physical and occupational therapy referral. A review of a care plan titled falls and last updated on 09/17/12 indicated Resident #170 was at risk for falls and the last fall occurred on 09/04/12. The approaches indicated to encourage resident to ask for assistance, keep frequently used items within reach, place scoop mattress on bed, bed alarm and chair alarm. A handwritten note on the back of the care plan for falls dated 09/17/12 indicated Resident #170 had multiple falls but only two (2) with minor injury. Soft mat at bedside was discontinued. During an observation on 09/19/12 at 8:43 AM Resident #170 was lying in bed with her eyes closed and her bed was in a low position and there were three (3) non-skid strips attached to	F 514	the Interdisciplinary review of resident incidents on Mondays and Fridays. Director of Nursing will report to Quality Assurance and Performance Improvement with identified trends or patterns. The identified trends or patterns will be reported to Quality Assurance and Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of close observation of execution and completion of In House Communication Tools for therapy evaluation will occur with additional staff education. Corrective action has been accomplished for Residents #53, #13, and #71 in regards to the alleged deficient practice. The Monthly Physician Orders Reconciliation and Medication Administration Records have been clarified for residents #53, #13, and #71 to include medication, proper dosage, and frequency in which the resident can receive the medication. All residents have the potential to be affected by the same alleged deficient 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 laws.	

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F 514	Continued From page 14 the floor beside her bed. During an interview on 09/19/12 at 8:49 AM Nurse #1 stated Resident #170 had a history of falls and thought she had a fall a week or so ago. She explained Resident #170 sometimes tried to get out of bed by herself. During an interview on 09/20/12 at 10:12 AM the Director of Nursing (DON) stated they discussed resident's risk for falls on a daily basis. She explained Resident #170 got out of bed by herself and they had tried various interventions to prevent her from falling. The DON confirmed the only therapy notes in Resident #170's medical record were from September 2011. During an interview on 09/20/12 at 10:20 AM a Rehabilitation Technician stated Resident #170 had not been on the therapy caseload for quite some time and she could not find any recent notes for physical therapy or occupational therapy. During an interview on 09/20/12 at 10:44 AM the Physical Therapy Rehabilitation Manager explained it was the usual process when a resident had a fall for nursing to fill out an "In-House Communication" form and send it to therapy so they could screen the resident to determine if a therapy evaluation should be done. She stated she did not get an In-House Communication Form after Resident #170's fall on 09/04/12. During an interview on 9/20/12 at 11:50 AM the Administrator explained the In House Communication Tool was the official document	F 514	practice. Director of Nursing, Assistant Director of Nursing, Unit Manager, and Health Information Coordinator have reviewed all physician orders during the monthly renewal to ensure that each resident order encompasses the medication, dosage, and frequency in which the physician orders have indicated the resident may receive the medication. This information was verified to be present on the monthly Physician Order Reconciliation and Medication Administration Record. Licensed Nurses and members of Administrative Nursing have received education by the Director of Nursing beginning on September 27, 2012, and concluding October 18, 2012 in regards to facility practice for physician order transcription, and review of the monthly Physician Order Reconciliation and Medication Administration Records to be inclusive of medication, proper dosage, and frequency to which the physician has indicated the resident can receive the medication. Any licensed nurse that was not able to attend the education programming prior to October 18, 2012, will be required to attend one on one education with the Director of Nursing prior to assuming their next assigned shift. Any newly hired licensed nurse will receive education on facility practice for 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 laws.	

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F 514	Continued From page 15 for referrals and anyone in the facility could fill it out. She stated therapy staff relied on this tool for referrals and confirmed there was a system break down when the In-House Communication Tool was not completed and therapy did not screen Resident #170 as recommended on the interdisciplinary post fall review form. 2. Resident #53 was admitted with diagnoses including Alzheimer's disease, depression, heart disease, high blood pressure and a stroke. The most recent annual Minimum Data Set (MDS) dated 06/29/12 indicated Resident #53 had impairment in short term memory, no impairment in long term memory and had some difficulty in new situations in cognition for daily decision making. The MDS also indicated Resident #53 had behaviors of hitting, scratching and throwing things and required extensive assistance from staff for activities of daily living. A review of the monthly physician's orders for 09/01/12 through 09/30/12 indicated Acetaminophen 325 milligrams (mg.) give two (2) tablets by mouth for pain. There was no frequency indicated for when to give the medication documented on the physician's orders. A review of the monthly Medication Administration Record (MAR) dated 09/01/12 through 09/30/12 indicated Acetaminophen 325 mg. tablet. There was no frequency for when to give the medication documented on the MAR. During an interview on 09/21/12 at 11:23 AM the Assistant Director of Nursing (ADON) explained	F 514	physician order transcription, and review of the monthly Physician Order Reconciliation and Medication Administration Records to be inclusive of medication, proper dosage, and frequency to which the physician has indicated the resident can receive the medication during orientation by either the Director of Nursing or designated Registered Nurse trainer prior to assuming the role of a medicating nurse. Administrative Nurses inclusive of the Director of Nursing, Assistant Director of Nursing, and Unit Manager will audit physician telephone orders a minimum of five days per week to ensure that each order is transcribed to the Medication Administrator Record with proper medication, dosage, and frequency for administration. These members of Administrative Nursing, as well as, licensed nursing personnel will be responsible for verifying during the monthly order processing that each medication ordered on the Physician Order Reconciliation and Medication Administration Record is inclusive of the medication, dosage, and frequency of intended administration. Director of Nursing will report to Quality Assurance and Performance Improvement with identified trends or patterns. The 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 laws.	

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F 514	Continued From page 16 at the end of each month they pulled residents charts and entered physician orders in the computer system from the previous month's physician orders and all new or revised orders. She further explained they double checked them to make sure every order was entered. She stated after they entered the information they printed it and created the physician's orders that were placed in the medical record. She further stated the MAR's were directly printed from the physician's order sheets. During an interview on 09/21/12 at 11:39 AM the Director of Nursing (DON) explained they had identified a problem where the frequency of medications had dropped off the physician's orders and MAR's and it was primarily pain medication orders as needed (PRN). She stated it was her expectation for nursing staff to hand write the frequency on the physician's orders and MAR if it was not present. During a follow up interview on 09/21/12 at 12:46 PM the DON verified the physician's order sheet and MAR had no frequency for dosing of Acetaminophen and nursing staff had not written in the frequency of when the medication should be given. 3. Resident #13 was admitted with diagnoses including paralysis, contractures and depression. The most recent annual Minimum Data Set (MDS) dated 06/29/12 indicated Resident #13 had no impairment in short term or long term memory and no impairment in cognition for daily decision making.	F 514	identified trends or patterns will be reported to Quality Assurance and Performance Improvement Committee weekly for four weeks and then monthly for three months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified, and adjust the plan if negative trends are identified. If negative trends are identified, additional months of daily and weekly audits for accuracy of transcription and monthly review of Physician Order Reconciliation and Medication Administration Records will occur with additional staff education. Date of Completion: October 19, 2012 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 laws.	10/19/12

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F 514	Continued From page 17 A review of the monthly physician's orders for 09/01/12 through 09/30/12 indicated Acetaminophen 325 milligrams (mg.) give two (2) tablets by mouth for pain. There was no frequency for when to give the medication documented on the physician's orders. During an interview on 09/21/12 at 11:23 AM the Assistant Director of Nursing (ADON) explained at the end of each month they pulled residents charts and entered physician orders in the computer system from the previous month's physician orders and all new or revised orders. She further explained they double checked them to make sure every order was entered. She stated after they entered the information they printed it and that created the physician's orders that were placed in the medical record. She further stated the MAR's were printed directly from the physician's order sheets. During an interview on 09/21/12 at 11:39 AM the Director of Nursing (DON) explained they had identified a problem where the frequency of medications had dropped off the physician's orders and MAR's and it was primarily for pain medication orders as needed (PRN). She stated it was her expectation for nursing staff to hand write the frequency on the physician's orders and MAR if it was not present. During a follow up interview on 09/21/12 at 12:46 PM the DON verified there was no frequency of dosing Acetaminophen on the physician's orders and nursing staff had not written in the frequency of when the medication should be given. 4. Resident #71 was admittted to the facility on	F 514	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 laws.	

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F 514	Continued From page 18	F 514		

12/01/06 with diagnosis including diabetes mellitus, senile delusion, psychosis, coronary athrosclerosis, hypertension, and peripheral vascular disease.

The most recent Minimum Data Set (MDS) dated 08/10/12 revealed Resident #71 was severely cognitively impaired. The MDS indicated she received scheduled pain medications and non medication
interventions for pain.

Review of the monthly physician orders dated 09/01/12 through 09/30/12 revealed an order for Resident #71 for Acetaminophen 325 mg two tablets give 650 mg total dosage po. No frequency when to give the medication was included in the order for the medication.

Review of the Medication Administration Record (MAR) dated 09/01/12 through 09/30/12 revealed a hand written order for Acetaminophen 325 mg two tablets po every four hours for pain as needed.

An intereview was conducted on 09/21/12 at 11:23 AM with the Assistant Director of Nursing (DON). She explained at the end of each month they pulled residents charts and entered physician orders in the computer system from the previous month's physician orders and all new or revised orders. She further explained they double checked them to make sure every order was entered. After they entered the information they print it and that creates the physician's orders that are placed in the medical record and then the MAR's are printed from the physician order sheets.

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F 514	Continued From page 19 An interview was conducted on 09/21/12 at 11:39 AM with the Director of Nursing (DON). She explained they had identified a problem that the frequency of medications had dropped off the phsyician's orders and MAR's and it was primarily for pain medication orders as needed (PRN). She stated it was her expectation for nursing staff to hand write the frequency on the physician's orders and MAR if it was not present.	F 514		