

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

PRINTED: 10/04/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____  OCT 17 2012	(X3) DATE SURVEY COMPLETED  C 09/20/2012
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944
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F 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited as a result of a complaint investigation conducted 09/17/12 to 09/20/12, Event ID # 9YEP11.</p> <p>F 246 SS=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to position call bell equipment in reach of 1 of 40 (resident #35) sampled residents. Findings include: A review of resident # 35 medical record revealed Resident #35 had a fall at the facility on 2/14/12 resulting in a hip fracture. A surgical repair was done at the hospital and resident #35 returned to the facility on 2/20/12. Resident #35 was readmitted to the hospital on 7/19/12 for a total hip replacement due to failure of the original orthopedic fixation. Resident #35 was readmitted to the facility on 7/24/12 after a total hip replacement. Other diagnoses for resident #35 include macular degeneration, arthritis, and dementia.</p> <p>The 30 day Minimum Data Set (MDS) dated</p>	F 000	<p>"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."</p> <p>F-246</p> <p>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 35 call bell in place and functioning 9/20/12</p> <p>2. Facility residents who have the potential to be affected by the same alleged deficient practice were evaluated on 9/20/12 to assure each had a functioning call bell located within reach.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Jessica S. Welcher RN, LNA* TITLE  
10/13/12 (X8) DATE

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 246

Continued From page 1  
8/21/12 indicated resident #35 was moderately cognitively impaired for decision making. Resident #35 was usually able to make her needs known and usually understood others. Resident #35 required extensive assistance for hygiene, toileting, dressing, and ambulation.

An observation on 9/20/12 at 10:20 AM revealed resident #35 was sitting in a wheelchair positioned between the two beds in her room. The call bell was positioned behind the resident on her bed. An observation of resident #35 's wheelchair revealed 2 personal alarm devices were in use. Fall mats were positioned on the floor on both sides of resident #35 's bed which was nearest to the door. Cords from the low pressure air mattress were positioned at the end of the bed; coiled and protruding about one foot from the end of the bed near the doorway of the room.

During an interview on 9/20/12 at 10:20 AM resident #35 the resident indicated she had just had breakfast and was resting in her chair. Resident #35 indicated she did not see well.

On 9/20/12 at 10:30 AM an interview with NA #2 revealed resident #35 was able to make her needs known and was able to use her call light to call for assistance. NA # 2 indicated resident #35 used to be a falls risk and was unsure if she was now. NA #2 indicated that resident #35 was sort of a falls risk still since they use a low bed, personal alarms and fall mats. NA #2 indicated she was not caring for resident #35 today but had taken care of her a lot of times and was familiar with her needs.

F 246

3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Re-education of Certified Nursing Assistants on 10/12 regarding placement of call bell and will continue until complete by the Staff Development Coordinator. Licensed staff re-education on 10/11 regarding call bell placement and will continue until complete by the Director of Nursing. Ambassadors were re-educated on 10/8 by the administrator regarding call bell placement and monitoring for placement. Director of Nursing, Staff Development Coordinator/designee to audit call bell placement on 5 residents every shift x 2 weeks then 5 residents weekly x 2 weeks then 5 residents monthly x 2 months.

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F 246	<p>Continued From page 2</p> <p>On 9/20/12 at 10:35 AM an observation revealed resident #35 remained in her wheelchair in her room and her call bell was not positioned within her reach.</p> <p>On 9/20/12 at 10:50 AM Nurse #5 entered resident #35 's room and offered the resident a snack and assisted resident #35 to stand to reposition herself in the wheelchair.</p> <p>An interview on 9/20/12 at 10:55 AM with Nurse #5 revealed she was the nurse caring for resident #35 and resident #35 was able to use her call bell and make her needs known.</p> <p>An observation 9/20/12 at 11:00 AM revealed resident #35 's call light was not in reach.</p> <p>An interview on 9/20/12 at 11:00 AM with NA#3 indicated she was caring for resident #35 today and was assigned on the 200 hall and the 300 hall. NA #3 revealed resident #35 needed total care for Activities of Daily Living and resident #35 would let you know her needs. NA # 3 revealed resident #35 would call out if she needed assistance and NA # 3 indicated resident #35 would not know how to use the call bell. NA #3 revealed resident #35 had a seat belt for fall prevention and the staff would try to get resident #35 to activities to keep her busy so resident#35 would not try to stand up on her own. NA# 3 also indicated she would try to toilet resident #35 every couple of hours so resident #35 would not try to get up and go on her own.</p> <p>On 9/20/12 at 11:25 AM DON and NA#3 entered resident #35 's room and shut door. At 11:45 AM resident #35 observed to be dressed (had been in</p>	F 246	<p>4. The Director of nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance.</p>	11/3/12

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F 246	<p>Continued From page 3 nightgown) and bought resident #35 to an activity.</p> <p>On 9/20/12 at 12:00 PM an observation revealed a staff member returned resident #35 to her room and resident #35 was positioned seated in her wheelchair between the beds with the call bell not in reach of resident #35. The call bell was positioned on resident #35 ' s bed.</p> <p>On 9/20/12 at 12:05 PM an interview with Nurse #5 revealed resident #35 should have had her call bell in reach and where it was positioned on resident #35 ' s bed was not in reach. Nurse #5 indicated she would reposition the call light.</p> <p>During an observation on 9/20/12 at 12:07 PM Nurse #5 reoriented resident #35 to the use of the call bell. Resident #35 was able to demonstrate how to use the call bell two times and indicated she knew what the call bell was for.</p> <p>An interview on 9/20/12 at 12:25 PM with the DON and the Regional Nurse Consultant revealed they would expect the call bell to be in reach of resident #35.</p>	F 246		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and</p>	F 312		

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F 312	<p>Continued From page 4</p> <p>record reviews, the facility failed to assist with toileting needs for 1 (Resident #90) of 7 sampled residents who required assistance with toileting.</p> <p>Findings included:</p> <p>Resident #90 was admitted to the facility 7/16/12 with diagnoses to include Dementia and glaucoma.</p> <p>The resident's admission Minimum Data Set (MDS) of 7/23/12 revealed the resident required extensive assistance of 2 plus staff members for transfer, dressing, and toileting. The assessment indicated the resident required extensive assistance of 1 staff member for personal hygiene. The resident was assessed as always incontinent of bowel and bladder</p> <p>Review of the resident's care plan, dated 7/30/12 revealed a problem identified as "(Resident #90) requires staff assistance and intervention for completion of (Activity of Daily Living) needs. Requires extensive/total care utilizing 1/2 staff members. Care plan intervention included " Offer/assist to toilet frequently and as accepted ".</p> <p>Observation of the resident on 9/20/12 at 10:12 AM revealed the resident was in a low bed resting on his right side with a spread cover over his body to his neck. The spread was wrapped around the resident. An outline of a darkened area of the bottom sheet under the resident was noted and extended from side to side of the bed and from the resident's head to mid-thigh. The edges from 10 o'clock to 2 o'clock were yellowish brown. The resident ' s bed was positioned against the wall in front of the door. The privacy</p>	F 312	<p>F 312</p> <p>"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."</p> <p>1. Corrective action has been accomplished for the alleged deficient practice in regards to</p> <p>Resident # 90 by assisting with toileting to maintain personal hygiene.</p>	

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F 312	<p>Continued From page 5</p> <p>curtain was pulled across the resident ' s foot of the bed. The resident roused slightly when his name was called and repositioned himself, but remained on his right side</p> <p>During an observation of the resident with the Director of Nursing (DON) on 9/20/12 at 10:45 AM, the resident remained in the bed resting on his right side. During an observation of the sheet the resident rested, the DON stated the resident had been wet for a long time. Observation of the resident ' s brief revealed the brief was loosely in place.</p> <p>During an interview with NA (Nursing Assistant) #2 on 9/20/12 at 10:48 AM, the NA stated the resident didn't urinate in the brief, but pulled the brief aside, pulled out his private parts, and urinated while in the bed. The NA stated the resident was continent when you took him to the bathroom. The resident was transferred from the bed and assisted to the bathroom by NA #2.</p> <p>During an observation with NA #3 on 9/20/12 at 10:54 AM, the NA pulled the covers from the bed, the bottom sheet was wet from edge to edge of the bed and 3/4;s of the sheet from top to bottom. The mattress had a large wet and stained area under the sheet as well and a strong urine odor.</p> <p>During an interview with the NA #4 assigned to the resident, on 9/20/12 at 11:12 AM, the NA stated she last checked Resident #90 after breakfast about 9 AM and the resident was dry. The NA stated she checked his brief and it was dry, she didn't notice any wet sheet. The NA stated she should have taken him to the bathroom to toilet at that time since he had just</p>	F 312	<p>2. Facility residents who are incontinent and require assistance with toileting have the potential to be affected by the same alleged deficient practice. The Resident Care Management Director for residents who trigger for low risk incontinence who lose control of their bladder and bowel completed an audit on 9/25/12. The residents identified were evaluated by the interdisciplinary team to determine a toileting plan if appropriate. New admissions will be evaluated by the interdisciplinary Team. Residents will be evaluated on admission, quarterly, annually and with significant change of status, utilizing the Bowel and Bladder evaluation tool.</p>	
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F 312	Continued From page 6 finished eating breakfast.	F 312	3.Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Re-education of the Certified Nursing Assistants on providing incontinent care and toileting assistance will be provided beginning 10/12/12 and continue until completion by the Director on Nursing and the Staff Development Coordinator. Licensed staff will be re-educated by the Director of Nursing on 10/11/12 on the Bowel and Bladder Management System and will continue until complete. The Director of Nursing, Staff Development Coordinator/designee will randomly audit 3 resident per day that are dependant on staff for toileting assistance to ensure the toileting plan is effective x 2 weeks, than 3 residents per week x 2 weeks, then 3 residents monthly x 2 months.	
F 313 SS=D	<p>An interview with the DON on 9/20/12 at 6:41 PM revealed the DON expected the resident should have been taken to the bathroom after breakfast.</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide glasses for 1 (Resident #9) of 1 resident reviewed for vision. Findings include:  Resident #9 was admitted to the facility on 08/23/06. Cumulative diagnoses included diabetes mellitus, diabetic retinopathy and cataracts.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 08/03/12, indicated Resident #9 was alert and oriented, and able to make decisions about her daily care. The assessment revealed the resident required extensive assistance with most activities of daily living with</p>	F 313		

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F 313

Continued From page 7  
 the exception of bathing and personal hygiene for which she needed only supervision. The assessment did indicate the resident did not wear glasses and needed large print for reading.

Review of the Care Area Assessment (CAA) sheet did not reveal vision had been identified as a need for review.

Review of an ophthalmologist consultation visit, dated 04/19/12, indicated Resident #9 saw the physician for dilatation of her eyes as a follow up for non-proliferative diabetic retinopathy (NPR) (NPR is small areas of balloon-like swelling in the retina's tiny blood vessels.) The report relayed the resident's NPR and cataracts were stable. There was a prescription given to the resident for glasses that included the instructions that read in part: "it is okay to use +3.25 (sphere) OTC (over the counter) reading glasses"  
 On 09/19/12 at 10:00 AM, Resident #9 was observed for a dressing change. The resident was not observed to have glasses.

An interview, on 09/20/12 at 12:15 PM, was conducted with Resident #9. When asked if she had glasses she stated she did not because Medicaid no longer paid for glasses and she could not afford them.

An interview, on 09/20/12 at 5:30 PM, was conducted with the Director of Nursing (DON), who had recently come to the facility. She indicated when she asked about the resident and glasses one of the nurses who remembered the issue relayed when the consultation report was received the nurse asked the family and they said they could not purchase them.

F 313

4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance.

F 313

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1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 9 by acquiring the glasses.

11/3/12



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An interview, on 09/20/12 at 5:50 PM, was conducted with the Business Office Director (BOM). The BOM relayed that in April of 2011 Medicaid stopped paying for glasses for people over 21 years of age. She went on to say that when a resident had a need for glasses the family would be asked if they could purchase them. The BOM indicated if the family can not and it is something that affects the resident 's quality of life the facility would purchase. She indicated if she would have received a request she would have given the information to the Administrator. When asked if she was aware of Resident #9 's need for glasses she stated she was not.

An interview, on 09/20/12 at 6:14 PM, was conducted with Nurse #2. She relayed she was not part of the process, but remembered the discussion that Medicaid would not pay for the glasses. She stated the family was asked and was not able to pay for them. She indicated she was unsure of what happened after that.

An interview, on 09/20/12 at 7:22 PM, was conducted with the DON. The DON relayed that when the nurse received a consultation report with orders, the nurse would be expected to handle them as any orders and follow them through until completed.

On 09/20/12 at 7:30 PM, the Administrator approached and stated the facility was not aware the over the counter option was available.

F 313

2. Facility resident who are in need of eye glasses have the potential to be affected by the same alleged deficient practice. The Social Worker completed an audited on ophthalmology consults to validate that all consultant recommendations for the pervious 12 months have been addressed by the attending physician and any orders required have been implemented.

3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Licensed Staff will be re-educated on 10/11/12 by the Director of Nursing on the process for obtaining orders when a resident returns from an eye appointment with recommendations and will continue until complete. The Interdisciplinary Team will review all Ophthalmology consults Monday thru Friday during the Interdisciplinary Team morning meeting to validate that Ophthalmology recommendations have been communicated to the attending physician and any orders have been acted upon x 3 months.

F 323  
SS=D

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards

F 323

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F 323	Continued From page 9 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to implement interventions to prevent falls for a resident identified as cognitively impaired with poor vision. Interventions included ensuring resident 's call bell equipment in reach and the use of a self releasing seat belt for 1 of 40 (resident #35) sampled residents. Findings include:  A review of resident # 35 medical record revealed resident #35 had a fall at the facility on 2/14/12 resulting in a hip fracture. A surgical repair was done at the hospital and resident #35 returned to the facility on 2/20/12. Resident #35 was readmitted to the hospital on 7/19/12 for a total hip replacement due to failure of the original orthopedic fixation. Resident #35 was readmitted to the facility on 7/24/12 after a total hip replacement. Other diagnoses for resident #35 include macular degeneration, arthritis, and dementia.  The care plan dated 8/3/12 indicated resident #35 was identified for falls with interventions which included fall mats beside the bed, chair and bed alarms, and placing the call bell in reach. The resident was also identified for vision and cognition impairments.	F 323	4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance.  F-323  "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."  1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 35's self releasing seat belt order was transcribed to the Medication Administration Record for licensed staff to monitor every shift regarding functioning and placement on 9/20/12. Call bell in reach on 9/20/12.	11/3/12

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F 323	<p>Continued From page 10</p> <p>A record review revealed on 8/17/12 at 9:25 AM resident #35 had a fall. Resident #35 was found on the floor. An Interdisciplinary Post Fall Review form dated 8/20/12 revealed a new intervention called a safety belt was ordered and to be worn by resident #35 while in the wheelchair.</p> <p>The 30 day Minimum Data Set (MDS) dated 8/21/12 indicated resident #35 was moderately cognitively impaired for decision making. Resident #35 was usually able to make her needs known and usually understood others. Resident #35 required extensive assistance for hygiene, toileting, dressing, and ambulation. The MDS was not coded for restraint usage.</p> <p>A record review revealed an Interdisciplinary Post Fall Review for which indicated on 9/5/12 at 3: 50 PM resident #35 slid out of the wheelchair onto the floor. The summary of the Interdisciplinary Team recommendations was not to leave resident #35 in her wheelchair in her room unattended. There were no new interventions initiated on the form or documentation indicating whether the seat belt device was in use for resident #35.</p> <p>An observation on 9/20/12 at 10:20 AM revealed resident #35 was sitting in a wheelchair positioned between the two beds in her room. There was a light blanket on resident #35 ' s lap and the observation revealed there was no seat belt on resident #35 ' s lap. The call bell was positioned behind the resident on her bed. An observation of resident #35 ' s wheelchair revealed 2 personal alarm devices were in use. Fall mats were positioned on the floor on both</p>	F 323	<p>2.Facility residents at risk for falls have the potential to be affected by the same alleged deficient practice. Residents will be identified by reviewing the current fall risk assessment. The Director of Nursing/designee will validate the interventions developed by the interdisciplinary team and ensue they have been implemented and documented on the care plan, care cardex and Medication Administration Record if indicated.</p>	

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F 323	<p>Continued From page 11</p> <p>sides of resident #35 ' s bed which was nearest to the door. Cords from the low pressure air mattress were positioned at the end of the bed; coiled and protruding about one foot from the end of the bed near the doorway of the room.</p> <p>During an interview on 9/20/12 at 10:20 AM resident #35 the resident indicated she had just had breakfast and was resting in her chair with a light blanket on her lap. Resident #35 indicated she did not see well.</p> <p>On 9/20/12 at 10:35 AM an observation revealed resident #35 remained in her wheelchair in her room and her call bell was not positioned within her reach. The call bell was behind resident # 35 near the head of the bed.</p> <p>On 9/20/12 at 10:50 AM Nurse #5 entered resident #35 ' s room and offered the resident a snack and assisted resident #35 to stand to reposition herself in the wheelchair. Nurse #5 left resident #35 ' s room after 5 minutes. Resident #35 was observed in her wheelchair, no seat belt device in use and the resident ' s call bell was not within reach.</p> <p>An interview on 9/20/12 at 10:55 AM with Nurse #5 revealed she was the nurse caring for resident #35 and resident #35 was able to use her call bell and make her needs known. Nurse #5 revealed her assignments varied because she floated but she was familiar with resident #35. Nurse #5 indicated she received report at the beginning of her shift as she does each day. Nurse #5 revealed resident #35 was at risk for falls and at one point they tried a seat belt and was unsure if resident #35 was still using one. Nurse #5</p>	F 323	<p>3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Directed in servicing related to fall management using the accepted Digital Versatile disk for citations 483.25(a) and (h) (1-2) that involve transfer, ambulation and accident or falls involving mobility problems. In addition the Director of Nursing will provide re-education to staff beginning on 10-11 and continuing until complete. Training will focus on fall management to include the implementation and staff communication of interventions. A falls risk assessment will be completed on Admission, Quarterly, Annually and with significant change in status for facility residents. Interventions will be developed and implemented for residents identified at risk by the Interdisciplinary Team. Resident fall interventions will be communicated to direct care staff by using the 24-hour report and the electronic care Cardex. The</p>	

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indicated resident #35 did not have a seat belt on when she went into the room a few minutes ago and she would check the physician orders and care plan to see if the seat belt was still ordered for resident #35.

An observation 9/20/12 at 11:00 AM revealed resident #35 ' s call light was not in reach. The call bell was positioned behind the resident on her bed. An observation of resident #35 ' s wheelchair revealed 2 personal alarm devices were in use. Fall mats were positioned on the floor on both sides of resident #35 ' s bed which was nearest to the door. Cords from the low pressure air mattress were positioned at the end of the bed; coiled and protruding about one foot from the end of the bed near the doorway of the room.

An interview on 9/20/12 at 11:00AM with NA#3 indicated she was caring for resident #35 today and was assigned on the 200 hall and the 300 hall. NA #3 revealed resident #35 needed total care for Activities of Daily Living and resident #35 would let you know her needs. NA # 3 revealed resident #35 would call out if she needed assistance and NA # 3 indicated resident #35 would not know how to use the call bell. NA #3 revealed resident #35 had a seat belt for fall prevention and the staff would try to get resident #35 to activities to keep her busy so resident#35 would not try to stand up on her own. NA# 3 also indicated she would try to toilet resident #35 every couple of hours so resident #35 would not try to get up and go on her own. NA #3 revealed she would keep objects that resident #35 would like in reach and she would make sure there was nothing in her path if she tried to stand up and go to the bathroom. NA#3 also indicated resident

F 323

Director of Nursing/designee, will audit 5 resident daily x 2 weeks, then 5 residents weekly x 2 weeks then 5 resident monthly x 2 months who are at risk for falls to validate that interventions are in place and communicated to direct care staff.

. 4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance.

11/3/12

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Continued From page 13  
 #35 was usually more active in the afternoon and usually made attempts to get up out of her wheelchair.

On 9/20/12 at 11:25 AM the DON and NA#3 entered resident #35 ' s room and shut door. At 11:45 AM resident #35 observed to be dressed (had been in nightgown) and brought resident #35 to an activity.

On 9/20/12 at 12:00PM an observation revealed a staff member returned resident #35 to her room and resident #35 was positioned seated in her wheelchair between the beds with the call bell not in reach of resident #35. The call bell was positioned on resident #35 ' s bed.

On 9/20/12 at 12:05 PM an interview with Nurse #5 revealed resident #35 should have had her call bell in reach and where it was positioned on resident #35 ' s bed was not in reach. Nurse #5 indicated she would reposition the call light.

During an observation on 9/20/12 at 12:07 PM Nurse #5 reoriented resident #35 to the use of the call bell. Resident #35 was able to demonstrate how to use the call bell two times and indicated she knew what the call bell was for.

An interview on 9/20/12 at 12:25PM with the DON and the Regional Nurse Consultant revealed they would expect the call bell to be in reach of resident #35. The DON indicated resident #35 was able to make her needs known and at times does not like to come out to activities. The DON indicated resident #35 would come out to the nurses ' station and the staff was able to more closely watch her.

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F 329  
SS=D

483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

F 329

F 329

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

"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."

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 22 AIMS testing completed 9/18/12

This REQUIREMENT is not met as evidenced by:  
Based on staff interviews and record reviews, the facility failed to monitor 1 (Resident #22) of 8 sampled residents requiring monitoring for abnormal involuntary movements.

2. Facility resident who are prescribed antipsychotic medications have the potential to be affected by the same alleged deficient practice. Residents will be identified utilizing Pharmacy reports and reviewing medications for new admissions by the interdisciplinary Team during the IDT meeting. A current AIMS test will be validated/completed for identified residents.

Findings include:  
Review of a facility policy and procedure,

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undated, entitled " Abnormal Involuntary Movement Scale (AIMS) ", revealed the assessment purpose was documented as " To monitor the development of involuntary movement disorders from drug-induced Parkinsonian types of symptoms to tardive dyskinesia ". The form indicated the assessment was to have been completed at the initiation of antipsychotic drugs use and every 6 months ongoing.

Resident #22 was admitted to the facility on 7/2/12 with a diagnosis to include Alzheimer ' s with dementia and behavior disturbance. Review of the physician ' s admission orders revealed an order for Seroquel (antipsychotic medication) 200 mg (milligrams) (Extended Release) at bedtime. Review of the resident ' s September 2012 physician ' s orders revealed the resident continued to receive Seroquel 200 mg at bedtime.

Review of a facility form entitled "Psychoactive Medication Evaluation" dated 7/2/12, revealed the diagnosis for the use of Seroquel was documented as a behavior disorder. Adverse reactions included: "none present". Record review revealed no AIMS assessment in the resident ' s record. An AIMS assessment for Resident #22 was not available during the survey.

During an interview with the Staff Development Coordinator on 9/18/12 at 5:03 PM, the nurse reported the facility completed AIMS assessments for residents who received antipsychotic medications. The SDC located blank forms in the cupboard at the nurse desk that was available to all nurses.

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3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Re-education of Licensed Staff by the Director of Nursing beginning on 10-11 and continuing until complete will focus on addressing the requirement of the AIMS assessment with the use of Antipsychotic Drugs/Reglan. The AIMS testing assessment will be included in the admission packet for completion by Licensed staff if the Resident is receiving an Antipsychotic Medication. The Director of Nursing/designee will review new admissions for AIMS testing in the interdisciplinary team meeting daily Monday thru Friday for need of AIMS testing x 3 months Weekend admissions will be reviewed on Mondays. The Director of Nursing or designee will audit 3 resident per week x 4 weeks, than 3 resident monthly x 2 months for residents receiving antipsychotic medications/ Reglan to ensure a current AIMS test is in the medical record.



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F 329	Continued From page 16 An interview with the Resident Care Management Director at 5:06 PM on 9/18/12, revealed the AIMS assessments were completed on a resident 's admission, when any antipsychotic medication was started, and then quarterly.  During an interview with the Director of Nursing (DON), on 9/20/12 at 6:02 PM, the DON reported she expected to see an AIMS assessment be completed on admission for residents on antipsychotic medications	F 329	4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance	11/3/12	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 3 errors out of 52 opportunities for error, resulting in an error rate of 5.7% for 3 of 10 residents observed during medication pass (Resident #99, #28 and #47). The findings include:  1. Resident #99 was admitted to the facility on 09/11/12 with cumulative diagnoses of status post open repair (of) bilateral quadriceps tendon.  Review of the admission physician 's orders, dated 09/11/12, revealed an order to give Lovenox 30 mg (milligrams) subq (subcutaneous) bid (twice a day) for 10 days.	F 332	F 332  "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 332	<p>Continued From page 17</p> <p>Per the manufacturer ' s information, Lovenox is an anticoagulant given to reduce the risk of developing deep vein blood clots in patients on bed rest.</p> <p>09/19/12 at 8:45 AM, an observation of a medication administration pass was made. Nurse #2 was observed to review the MAR (Medication Administration Record), prepare medication for Resident #99, and proceeded into the resident ' s room to administer the medication. After the medication had been taken by the resident, the resident asked the nurse about her injection and Nurse #2 relayed the medication had been discontinued.</p> <p>Review of the September 2012 MAR revealed a block of dates identified for the administration of Lovenox and a note on the MAR for the stop date for Lovenox to be after the last dose on 09/20/12.</p> <p>09/19/12 11:50 AM the MAR for Resident #99 was reviewed with Nurse #2 and she indicated when she had looked at the MAR, she saw the stop date and thought the medication had been discontinued.</p> <p>An interview, on 09/20/12 7:20 PM, was conducted with Director of Nursing (DON). She stated she would have expected the nurse to have given the medication per the physician's order and written on the MAR.</p> <p>2. Resident #28 was admitted to the facility on 06/20/12 with multiple diagnoses including Heartburn.</p>	F 332	<p>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 99 a medication Variance was completed. Physician and family notified, new order received to give Lovenox and to resume current medication schedule. Resident # 28 Medication Variance was completed. Physician and Responsible Party notified and no new orders received, Resident # 47 Medication variance completed and Physician and Responsible party notified. No new orders continue current schedule.</p> <p>2. Facility resident have the potential to be affected by the same alleged deficient practice. The Director of Nursing and Staff Development Coordinator and Omniview Nurse Consultant began Medication Pass Audits on 9/20 /12 for Licensed Nurses and will continue until all have been completed. Skill validated tool for competency skills with medication Administration.</p>	

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A review of the admission orders dated 06/20/12 revealed an order that read: "Gas-x 2 tabs PO (by mouth) after meals qd (every day)."

A review of the resident ' s medication administration record (MAR) for September 2012, revealed instructions that read: " simethicone 125mg Tablet, chewable (Gas Relief Extra Strength 125mg tablet, Chewable) 2 tablets by mouth (PO) TID (three times a day). "

A review of the resident ' s medication administration record (MAR) for September 2012, revealed instructions that read: " simethicone 125mg Tablet, chewable (Gas Relief Extra Strength 125mg tablet, Chewable) 2 tablets by mouth (PO) TID (three times a day). "

In an observation of medication pass on 09/19/12 at 8:30 AM, Nurse #1 was observed to administer Tums, 2 chewable tablets to the resident.

The active ingredient in tums is calcium carbonate and is used to treat acid indigestion and is also used as a dietary supplement. The active ingredient in gas-x is simethicone that reduces the formation of trapped gas bubbles and allows the body to get rid of the gas naturally.

In an interview on 09/19/12 at 8:40 AM, the consulting pharmacy ' s Nurse Consultant stated that tums is calcium carbonate and not simethicone and that the nurse made a medication error.

Nurse #1 stated in an interview on 09/19/12 at 10:08 AM that she thought that simethicone was tums and did not realize that it was gas-x.

F 332

3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Directed inservicing North Carolina Board of Nursing to come to facility and train Licensed Staff on Documentation and Medication errors on 11/02/12. Licensed staff will not be allowed to work until they have received the training after 11/02/12. In addition Licensed staff to view the facility training DVD on part one and part two of the medication management system. Each Nurse must pass a posttest and successfully complete Medication Pass audits. The Director of Nursing /designee will conduct random med pass audits 2 per week x 4 weeks, than 2 per month x2 months.

4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance.

11/3/12

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(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
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F 332

Continued From page 19

The Director of Nursing stated in an interview on 09/20/12 at 10:31 AM that it was her expectation that the nurses give the medications as ordered and as written on the MAR.

3. Resident #47 was admitted to the facility on 03/04/08 and had multiple diagnoses including Prostate Cancer.

The monthly physician ' s orders for September 2012 revealed an order for flomax 0.4mg ER (extended release), 1 capsule by mouth every other day.

A review of the medication administration record (MAR) for September 2012 revealed instructions to administer flomax 0.4mg ER 1 capsule every other day and gave instructions to administer the medication 30 minutes after the same meal every other day at 6:30 PM.

Lexicomp ' s Geriatric Dosage Handbook, 11th Edition under Dosage for flomax read: " 0.4mg once daily approximately 30 minutes after the same meal. "

On 09/19/12 at 5:06 PM, Nurse #1 was observed during a medication pass to administer Flomax ER (extended release) 0.4mg 1 capsule to Resident #47. Flomax is a medication used for the treatment of an enlarged prostate.

On 09/19/12 at 5:15 PM the Staff Development Coordinator stated that the evening meal was usually served around 5:30 PM.

Observations of the unit where the resident

F 332

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/20/2012
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944	
(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 332	Continued From page 20 resided revealed that at 5:30 PM, the evening meal had not yet been served.  A telephone interview was conducted with a pharmacist from the facility ' s consulting pharmacy on 09/20/12 at 9:03 AM. Pharmacist #1 stated that the manufacturer ' s specifications were to administer fIomax 30 minutes after the same meal each day because giving the medication on an empty stomach could increase side effects of the medication.  The Director of Nursing stated in an interview on 09/20/12 at 10:31 AM that it is her expectation that the nurses give the medications as ordered and written on the MAR.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to prevent a significant medication error by omitting to administer an anticoagulant medication ordered for 1 (Resident #99) of 1 residents. Findings include:  Per the manufacturer's information, Lovenox is an anticoagulant given to reduce the risk of developing deep vein blood clots in patients on bedrest.  Resident #99 was admitted to the facility on	F 333	F 333  "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."  1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 99 Medication Variance completed. Physician and Responsible Party notified. New order received to give dose now and resume current orders.	

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F 333

Continued From page 21  
09/11/12 with cumulative diagnoses of status post open repair (of) bilateral quadriceps tendon.

Review of the admission physician order for Resident #99, dated 09/11/12, revealed an order to give Lovenox 30 mg (milligrams) subq (subcutaneous) bid (twice a day) for 10 days. Further review of the admission orders revealed Resident #99 was to be non weight bearing and on bed rest for six weeks.

09/19/12 at 8:45 AM, an observation of a medication administration pass was made. Nurse #2 was observed to review the MAR (Medication Administration Record), prepare medication for Resident #99, and proceed into the resident ' s room to administer the medication. After the medication had been taken by the resident, the resident asked the nurse about her injection and Nurse #2 relayed the medication had been discontinued.

Review of the MAR revealed a block of dates identified for the administration of Lovenox and a note on the MAR for the stop date for Lovenox to be after the last dose on 09/20/12.

09/19/12 at 11:50 AM the MARS was reviewed with Nurse #2 and she indicated when she had looked at the MAR, she saw the stop date and thought the medication had been discontinued.

An interview, on 09/20/12 at 7:20 PM, was conducted with Director of Nursing (DON). She stated she would have expected the nurse to have given the medication per the physician's order.

F 333

2. Facility residents receiving anticoagulant therapy have the potential to be affected by the same alleged deficient practice. Facility residents were reviewed to determine anticoagulant use, these residents Medication administration records have been audited by the director of nursing for the accuracy of the order to include a stop date if indicated and/or omitted doses.

3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include: Directed inservicing by the North Carolina Board of Nursing to come to the facility and train Licensed Staff on Documentation and Medication errors on 11/02/12. After 11/2/12 licensed staff will not be allowed to work until they have received this training. In addition the Licensed staff will view the facility training DVD on part one and part two of the medication management system. Each Nurse must pass a posttest and successfully complete Medication Pass audits. Director of Nursing/designee will audit 2 resident on anticoagulation to assure there have been no omitted doses daily x 2 weeks, than 2 resident per week x 2 weeks than 2 residents per month x 2 months

F 356

483.30(e) POSTED NURSE STAFFING

F 356

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F 356 SS=C	<p>Continued From page 22 INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:               <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to maintain 18 months of staff postings. The findings include:</p>	F 356	<p>4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance</p> <p>F 356</p> <p>"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."</p> <p>1. Corrective action has been accomplished for the alleged deficient practice by developing a system going forward of keeping 18 months worth of staff posting</p> <p>2. Facility resident who have the potential to be affected by the same alleged deficient practice will be identified no residents affected.</p>	11/3/12
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F 356

Continued From page 23  
  
On 09/20/12 at 9:00 AM the last 2 weeks (09/08/12 through 09/20/12) of staff postings was requested from the facility. The staff postings for the 7AM shift for 09/10/12 and 09/14/12 and all three shifts for 09/17-20/12 were provided. The facility was unable to provide the remainder of the staff postings.

F 356

3. Systemic Measures put into place to assure that the same alleged deficient practice does not recur include; The Director of Nursing trained the Medical Records Clerk on the requirement for posting the nurse staffing data. Medical Record Clerk will keep the posting in her office for 18 months. The Director of Nursing/designee will conduct an audit weekly to ensure that all the prior 7 days are accounted for and filed in the medical records office. X 3 months

F 428  
SS=D

483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON

F 428

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  
  
The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

4. The Director of Nursing will review the audits analyze the data and report patterns and trends to the Quality Assessment and Assurance Committee monthly x 3. The committee will evaluate the effectiveness of the plan based on outcomes. Additional interventions will be developed by the committee and implemented to assure continued compliance

This REQUIREMENT is not met as evidenced by:  
Based on staff interviews and consultant pharmacist interview and record reviews, the facility failed to ensure the consultant pharmacist reported the need for an abnormal involuntary movement assessment for 1 (Resident #22) of 8 sampled residents receiving antipsychotic

11/3/12



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F 428	<p>Continued From page 24</p> <p>medication; and the facility failed to act on pharmacy recommendations for a medication change and laboratory tests for 1 (Resident #90) of 1 sampled residents with pharmacy recommendations.</p> <p>Findings include:</p> <p>1) Review of a facility policy and procedure, undated, entitled " Abnormal Involuntary Movement Scale (AIMS) ", revealed the assessment purpose was documented as " To monitor the development of involuntary movement disorders from drug-induced Parkinsonian types of symptoms to tardive dyskinesia ". The form indicated the assessment was to have been completed at the initiation of antipsychotic drugs use and every 6 months ongoing.</p> <p>Resident #90 was admitted to the facility on 7/16/12 with a diagnosis to include Alzheimer ' s with dementia and behavior disturbance. Review of the physician ' s admission orders revealed an order for Seroquel (antipsychotic medication) 200 mg (milligrams) (Extended Release) at bedtime. Review of the resident ' s September 2012 physician ' s orders revealed the resident continued to receive Seroquel 200 mg at bedtime.</p> <p>Review of a facility form entitled "Psychoactive Medication Evaluation" dated 7/2/12, revealed the diagnosis for the use of Seroquel was documented as a behavior disorder. Adverse reactions included: "none present". Record review revealed no AIMS assessment in the resident ' s record. An AIMS assessment for Resident #22 was not available during the survey.</p>	F 428	<p>"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."</p> <p>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 22 AIMS testing completed 9/18/12 Resident # 90 will transition to therapeutic interchange as recommended by the Pharmacy Consultant when current supply is exhausted. Labs will be drawn at that time.</p> <p>2. Facility resident who are prescribed medications have the potential to be affected by the same alleged deficient practice. The pharmacy consultant reports will be reviewed by the Director of Nursing/designee for the past 60 days to validate that the pharmacy recommendations have been reviewed by the attending physicians and orders will be processed as appropriate. The Director of Nursing or designee will identify Residents who utilize Antipsychotic Medications by reviewing the Pharmacy reports.</p>	

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F 428	<p>Continued From page 25</p> <p>Record review indicated the resident was reviewed by the pharmacist on 7/24/12 and formulated a plan for the resident with no documentation of an AIMS assessment. Review of a pharmacy recommendation of 8/20/12 indicated no recommendation for the need of an AIMS assessment for the resident.</p> <p>During a telephone interview with the facility Pharmacist #2 on 9/20/12 at 6/45 PM, the Pharmacist stated the facility standard for completing the AIMS assessments was every 3 months for residents receiving antipsychotic medications. The Pharmacist stated during his monthly review, he would also review the AIMS assessments for being up to date. The Pharmacist stated he would have made recommendations to the facility when an AIMS assessment was required if one had not been completed. The Pharmacist was not able to recall Resident #22 specifically.</p> <p>2) Resident #90 was admitted to the facility on 7/16/12 with a diagnosis to include hypercholesteremia (elevated cholesterol).</p> <p>Review of a pharmacy recommendation of 8/20/12 revealed a recommendation, in part, as " When the current supply of Simvastatin is exhausted, please consider changing to Atorvastatin (medication to lower high levels of cholesterol) 20 mg once daily in the evening then obtaining a follow up fasting lipid panel " .</p> <p>Review of the resident ' s admission orders of 7/16/12 revealed the resident was ordered</p>	F 428	Residents identified will have a current AIMS test validated/completed. New admissions will be reviewed for antipsychotic use by the Interdisciplinary Team in the morning meeting. Residents identified as being prescribed an antipsychotic medication will have a current AIMS validated/completed.	

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F 428	<p>Continued From page 26</p> <p>Simvastatin (medication to lower high levels of cholesterol) 40 mg (milligrams) every night. Review of the resident ' s September 2012 physician ' s orders revealed the resident continued to receive Simvastatin 40 mg every night. Review of subsequent orders revealed no orders for changes in the medication.</p> <p>A telephone call to the physician's office by the Staff Development Coordinator on 9/20/12 at 2:43 PM and subsequent interview with the SDC revealed the physician ' s office did not receive any pharmacy recommendation requests for lab tests.</p> <p>During interview with the Director of Nursing (DON) on 9/20/12 at 4:24 PM, the DON stated she was responsible for the pharmacy recommendations and not yet sent out the recommendations of 8/20/12. The DON stated she was late sending the recommendations to the physician ' s office for approval.</p>	F 428	<p>3. Measures put into place to assure that the same alleged deficient practice does not recur include: Pharmacist to be re-educated by Pharmacy Manager on the requirement for AIMS testing and his responsibility to report variances to the attending physician and the Director of Nursing on a monthly basis. The Consultant Pharmacist will give pharmacy recommendations to the Director of Nursing. The Director of Nursing will give the Pharmacy recommendation to the Medical records Clerk who will copy and send the originals to the attending physician for review. The Attending physician will address recommendation and return report to The Medical records Clerk who will validate we received the response and give the recommendation to the charge nurse who will process the orders. The Director of Nursing or designee will audit for order implementation and response to Pharmacy recommendations X 3 months</p>		

F-428

4. Director of nursing will review the audits analyze the data and report patterns and trends to the Quality Assurance Committee monthly x 3. The quality assurance committee will evaluate the effectiveness of the above plan monthly and will add additional interventions based on negative outcomes to assure continued compliance.

11/3/12

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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 11/02/2012 the door to the soiled linen side of the laundry failed to close and latch. 42 CFR 483.70 (a)</p>	K 029	<p>"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."</p> <ol style="list-style-type: none"> <li>1. Corrective action has been accomplished related to the door on the soiled linen side of laundry the closure was adjusted to allow the door to close and latch appropriately</li> <li>2. All doors in protected hazardous areas have been audit to assure they close and latch appropriately. Audit was completed on 11/9/12 all doors in hazardous areas close and latch appropriately.</li> <li>3. Systemic measures to prevent reoccurrence will be for the Maintenance Director to complete monthly audits of doors in hazardous locations. Negative findings will be corrected immediately. Results of audits will be reported to the safety committee monthly x3 then on going on a quarterly basis.</li> <li>4. The Maintenance Director will report results to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.</li> </ol>	11/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeresa S. Wilcher, RN, CNHA</i>	TITLE 11/16/12	(X6) DATE
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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.