STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER Revised	8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to review and revise the plan of care regarding not using the personal body alarm for 1 of 23 (Resident #10) sampled residents. Findings include: 1. Record review indicated that Resident #10 was admitted to the facility as a readmit on 3/21/2012 with diagnoses including dementia, hemiplegia or hemiparesis, and seizure disorder.	F 280	F 280 1 Resident #10's care plan was reviewed by DON, MDS Nurse, and/or LPN with chart & incident reports. Corrections /interventions were put into place on care plan and care guide. Body alarm is in place while in bed &/or wheelchair. 2. MDS Nurse &/or LPN conducted an audit of all Residents care plans and use of alarms with charts, physical assessments, & incident reports and care plans and care guides in closet doors were revised as needed. 3. MDS Nurse, Floor Nurse, RN Supervisor, will review audit of care plans and care guides for use of alarms with charts, physical assessments, & incident reports, care plans, & care guides daily for 3 weeks, then weekly x4 weeks to ensure alarms are in place if ordered and care plans and care guides are updated.	3-13-13 3-13-13 3-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annie Mallard	Administrator	3-18-13

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 280	Continued From page 1 The Admission Minimum Data Set (MDS) dated 8/7/2012 indicated the resident was severely cognitively impaired and was totally dependant on staff for care with 1 person assist with activities of daily living (ADL). The Resident ' s Bed mobility was noted to be extensive assistance from staff with 1 person assist. The Care Area Assessment (CAA) summary noted the following areas were addressed in the care plan: Communication, behavioral symptoms, falls, nutritional status, pressure ulcer, psychotropic drug use and pain. The MDS dated 11/6/2012 indicated that the resident was noted to be severely cognitively impaired and required total assistance with ADL ' s with the physical assistance of 1 person. The MDS dated 2/6/2013 indicated that the resident was moderately cognitively impaired and continued to be totally dependant on staff for ADL ' s with the physical assistance required of one person and bed mobility was noted to be extensive assistance with 1 person assist. Review of the resident ' s care plan dated 10/17/2011 indicated the facility had care planned the resident from a prior admission date but not on the readmission date of 3/21/12. Residents #10 ' s care plan listed the problems as: at risk for aspiration, weight loss, potential for falls, potential for skin breakdown, risk for psychotropic med side effects, at risk for abnormal bleeding related to Coumadin use, at risk for worsening contractures, Resident is a smoker at risk for wandering and injury, at risk for injury related to	F 280	Floor Nurses will continue to monitor all Residents daily and document on MAR's the use of personal body alarm will be on going. MDS's Nurse will continue to review weekly to ensure care guides and care plans are updated and this will be on going. 4. In-Service was completed by DON & LPN on 2/20/13, for Nursing Personnel in regards to monitoring and placement for all Resident's with personal body alarms. Audit of all Residents is completed every shift daily per Nursing staff by visualizing and physically assessing proper placement and use of personal body alarms. This will be evident by documenting placement acknowledgement per nursing initials on the treatment records every shift ensuring body alarms are present. If presence of alarm not noted the concern will be corrected immediately by placing personal body alarm on resident properly. Weekly audits	

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F 280	Continued From page 2 seizure disorder, agitation and yelling out. Review of Resident #10 ' s incident reports indicated that the resident had fallen on 12/15/12 with an intervention of " personal body alarm, low bed, and matt beside bed " . According to incident reports for Resident #10 for the last three months, the resident had also had falls on 12/17/12, 1/12/13, 2/4/13 that had stated in the interventions to continue personal body alarm, use of low rise bed, and the use of the floor matt next to the bed. The resident was observed in his room on multiple occasions during the survey. The resident was not witnessed to have a personal body alarm on at anytime during those observations. On 2/21/13 at 3:00 PM, Resident #10 was observed out of bed and sitting up in his wheelchair. The resident was not wearing a personal body alarm. At 3:40 PM on 2/21/13 NA#5 was interviewed. NA#5 stated that the resident does not have a personal body alarm in use. NA#5 indicated that she uses the nurse aide ' s information sheet inside the closet door to tell her how to care for the Resident. A facility form titled " nurse aide ' s information " sheet was located in the resident ' s room on inside of the resident ' s closet door and dated 2/20/13. The " nurse aide ' s information " form had documentation that the resident was at risk for falls and required a low bed and a matt beside the bed. Interviewed MDS nurse on 2/21/13 at 4:09 PM. The MDS nurse was shown the incident reports from 12/15/12, 12/17/12, 1/12/13, 2/4/13 that	F 280	of treatment records will be completed to identify a failure to follow care plans and physician orders. Monthly review will be discussed in regards to care plan accuracy and personal body alarm use during QA meeting. MDS Nurse, DON, and Administrator will discuss any identified concerns on ensuring corrections are achieved by in-servicing, auditing , and monitoring by the above named staff. Care plans and personal body alarms will be addressed in monthly QA meetings x3 months.	

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F 280	Continued From page 3 indicated the use of a personal body alarm. The MDS nurse stated that the intervention of a personal body alarm was not listed in the care plan and that " this is the first time I had seen them " referring to the incident reports. During an interview with the Director of Nursing (DON) on 2/21/13 at 8:40 AM the DON indicated that she expects care plans to be updated as needed.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to give medication as ordered by the physician for 3 of 10 (Resident #10, Resident # 11, and Resident #43) sampled residents. Findings Include: 1) Record review indicated that Resident #10 was admitted to the facility as a readmit on 3/21/2012 with diagnoses including dementia, hemiplegia or hemiparesis, and seizure disorder. The review of Resident #10 physician ' s orders revealed an order for atenolol 25 mg tablet take ½ tablet (12.5 mg) by mouth daily (hold if systolic blood pressure < 120) HTN (hypertension). Order as written on the MAR as follows: Atenolol 25 mg Tablet Tenormin 25 mg Tablet	F 281	F 281 Resident #10 1. Resident #10 receiving Atenolol. Correction was put into place by reporting medication error to DON and MD. Medication was D/C'd per MD and B/P was reviewed daily for a week and MD reviewed during next visit. 2. Audit of all Resident's medication records and physician orders has been completed by Pharmacy consultant, Medical Records, DON, and/or LPN determining if any Residents were receiving Blood pressure medications inappropriately with specific parameters ordered. (No other incidents were found).	3-22-13 3-22-13

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F 281	Continued From page 4 Take ½ tablet (12.5 mg) By mouth daily (hold if SBP <120) HTN Further review of the clinical record indicated that the medication had been given to the resident when the systolic blood pressure was below 120. Medication was given on the following dates with the corresponding systolic blood pressure: 10/4/12 SBP 118/70 10/5/12 SBP 116/70 10/6/12 SBP 112/76 11/3/12 SBP 112/66 11/12/12 SBP 100/74 12/5/12 SBP 118/78 12/6/12 SBP 100/76 12/9/12 SBP 99/56 1/1/13 SBP 104/60 1/2/13 SBP 119/68 1/6/13 SBP 100/60 1/9/13 SBP 98/83 1/11/13 SBP 118/54 1/12/13 SBP 99/82 1/13/13 SBP 98/68 1/17/13 SBP 102/62 1/25/13 SBP 96/54 1/28/13 SBP 115/64 1/29/13 SBP 114/50 An interview was conducted with nurse #1 on 2/20/13 at 11:50 AM indicated that the policy of the facility was to circle your initials on a medication that was being held. LPN #1 also indicated that if initials were placed in the box for a medication then the medication is indicated as being given on that date and time. The Director of Nursing (DON) was interviewed	F 281	3. DON and/or LPN in-serviced Nurses (2/22/13 to 3/19/13) on the correct method of giving/documenting Atenolol when specific parameters have been given. If medication is not warranted due to specific parameters Nurse is to circle initials indicating it was not given. Resident #11 1. Medication was discontinued for Resident #11 after orders were confirmed with MD during survey. 2. After visit to outside MD, Nurse will call MD office to confirm no new orders were given. Medical Records Person will obtain/ensure that progress notes of all residents with outside primary care physicians were placed on the charts from the past 2 visits. This will be on going. DON and/or LPN audited all Residents with outside primary care physicians by reviewing progress notes and physician orders of the past 2 visits for any	3-22-13 3-22-13 3-22-13

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F 281	Continued From page 5 on 2/21/13 at 3:10 PM and asked if there were any other places that pharmacy recommendations may be kept. The DON indicated that the recommendations that need to be seen by the Doctor like medication recommendations and gradual dose reductions are placed on the resident ' s chart for review. After review by the Doctor, they are signed to verify that they were seen by the Doctor. The DON stated that not all recommendations are seen by the Doctor and that they have a standing agreement with the Doctor that if the recommendation is a med time change or " something like that " the facility, mainly the DON, are able to write a verbal order from him to take care of those pharmacy recommendations. An interview with the DON on 2/22/13 at 8:44 AM indicated that her expectation was that medications would be given according to policy and procedure. 2) Resident #11 was admitted to the facility on 3/14/12 with multiple diagnoses including atrial fibrillation, cardiomyopathy and myocardial infarction. Review of the resident ' s clinical record revealed Resident #11 was seen for an office visit with her physician on 1/8/13 and MD Encounter Notes for this visit were electronically sent to the facility on 1/21/13 at 11:00 AM. The MD Encounter Notes indicated the physician ' s plan included discontinuation of several medications, including: furosemide 40 mg (milligrams) oral tablet (a diuretic) taken as 1 and 1/2 tablets daily; Liquitears 1.4% Ophthalmic Solution (an eye lubricant); metoprolol succinate 50 mg extended	F 281	discrepancies in medications that were ordered. Completed by 3/13/13 (No other incidents were found) 3. Appointment book will be reviewed daily by Medical Records to ensure progress notes are obtained from MD office once progress notes are received she will immediately give to Floor Nurse to check to ensure all orders are recorded if applicable. These progress notes will also be reviewed by medical records weekly during weekly medication audits. This will be on going. Resident #43 1. MD & DON were notified of medication error. Clarification order was received from MD and Resident's insulin sliding scale was discontinued. 2. An audit of all residents Physician orders and MAR's were reviewed by the Pharmacy Consultant starting on 3/1/13 and completed by 3/13/13 ensuring any d/c'd orders were removed from MAR's. (no other incidents were found.)	3-22-13 3-22-13 3-22-13

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F 281	Continued From page 6 release oral tablet (medication used for blood pressure and/or control of heart rhythm); Enulose 10 gm/15 ml oral solution (a laxative); and a multivitamin oral tablet with iron. Review of the resident ' s January 2013 and February 2013 Medication Administration Record (MAR) revealed Resident #11 continued to receive the furosemide, Liquitears Ophthalmic Solution, Enulose, multivitamin with iron. Resident was also receiving metoprolol tartrate (an immediate release formulation) as previously ordered by the physician. No orders were found on the resident ' s medical record to discontinue the medications. Each of these medications continued to be given through February 20, 2013. An interview with Nurse #3 was conducted on 2/20/13 at 3:30 PM regarding the discrepancy in medications discontinued and given. Nurse #3 indicated she would need to call the resident ' s physician office to clarify the medication orders. A follow-up interview with Nurse #3 was conducted on 2/20/13 at 4:10 PM. Nurse #3 indicated the MD office was contacted and MD clarified the medication orders. MD confirmed the furosemide, Liquitears, Enulose, and multivitamin with iron were to be discontinued. Resident was to continue to receive the Lopressor (metoprolol tartrate which is the immediate release formulation) 75 mg by mouth twice daily. Nurse #3 indicated she would write a telephone order to be put on the resident ' s chart indicating clarification of these MD orders. Nurse #3 indicated she would have expected a telephone order for any medication changes to have been put on the resident ' s chart	F 281	3. Floor Nurses, DON will review physician orders & MAR's daily x4 weeks to ensure all discontinued orders are removed from MAR's then medical records person will audit physician orders and MAR's weekly and Pharmacy consultant monthly to ensure all discontinued orders are removed from MAR's timely. This will be on going. 4. All monthly medication concerns/errors identified by the Pharmacy consultant and/or LPN will be discussed monthly during the QA meeting. The Administrator, DON, &/or LPN will ensure correction is achieved and maintained during the monthly QA meetings x 3 months.	3-22-13 3-22-13

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F 281	Continued From page 7 immediately after the office visit. An interview was conducted on 2/21/13 at 2:45 PM with the Director of Nursing (DON). The DON outlined the usual procedure followed when a resident goes out for a physician office visit included sending a blank Telephone Order form and progress note along with the patient for the appointment. This procedure allows the facility to have pertinent information when the resident returns. The DON stated that it looked like the physician had only sent back the Telephone Order form with a note for a " recheck in 4 months " . The MD Encounter Notes were sent to the facility on 1/21/13. The DON indicated it was unusual for the physician to communicate in this manner and concern as to why the progress notes (MD Encounter Notes) were sent to the facility 13 days after the MD visit. The DON also stated she was uncertain as to why the February Monthly Physician Orders were signed by the MD when the medications in question had not been changed in these orders. However, the DON stated, " I believe we are fully responsible and we will need to be checking this " (referring to MD Encounter Notes sent to the facility). 3) Resident #43 was admitted to the facility on 5/9/09. Cumulative diagnoses included diabetes. Review of the resident ' s clinical record revealed the Consultant Pharmacist completed a Medication Regimen Review for Resident #43 on 12/20/12 and made the following recommendation: " This resident has order for FSBS (fasting blood sugar) 3 times a week with sliding scale coverage. He was given 1 sliding scale dose in November for BS (blood sugar)	F 281		

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F 281	Continued From page 8 172. Please consider discontinuing the sliding scale to decrease risk of hypoglycemia (low blood sugar). " The resident ' s MD indicated agreement with the Consultant Pharmacist ' s recommendation and wrote an order dated 1/8/13 to discontinue insulin sliding scale coverage. A review of the January 2013 Medication Administration Record (MAR) revealed the sliding scale insulin coverage was discontinued in accordance with the physician ' s order on 1/8/13. A review of the printed February 2013 Monthly Physician Orders and February 2013 MAR revealed the sliding scale insulin coverage had not been discontinued as ordered. On 2/15/13, Resident #43 had a blood sugar of 155 mg/dl (milligrams per deciliter) and was given 2 units of Novolin R insulin in accordance with the previously prescribed sliding scale regimen. An interview was conducted on 2/21/13 at 10:37 am with Nurse #5. The nurse noted discontinuation of the sliding scale insulin coverage had not been noted on the February 2013 MAR. Nurse #5 stated she would have expected the facility ' s nurse checking orders for February to have noted any medications that had been discontinued or changed on the MAR. An interview with the DON was conducted on 2/21/13 at 2:45 PM. The DON indicated her expectation would have been for any medication changes from January to have been noted on the February Physician Orders and February MAR by the nurse responsible for checking orders at the change of the month.	F 281		

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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 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 observation, record review, and staff interview the facility failed to assess the resident for different interventions to prevent falls for 1 of 3 (Resident #10) sampled residents. Findings include: Record review indicated that Resident #10 was admitted to the facility as a readmit on 3/21/2012 with diagnoses including dementia, hemiplegia or hemiparesis, and seizure disorder. The MDS dated 2/6/2013 indicated that the resident was moderately cognitively impaired and continued to be totally dependant on staff for ADL ' s with the physical assistance required of one person and bed mobility was noted to be extensive assistance with 1 person assist. Incident reports for the last four months indicated that the resident had fallen on the following dates with interventions put in place as follows: 12/15/12 Interventions: " Personal body alarm (PBA) while	F 323	F 323 1. Personal body alarm is in place for Resident #10. A winged mattress has been placed on his bed to help prevent falling out of bed. A Rock N Go chair has been ordered for Resident #10 to help prevent falls while out of bed. DON and/or LPN conducted and In-service to Nursing personnel in regards to a trend in falls for resident #10 which was identified from incident reports from the past 3 months indicating falls occurring between 11am and 1pm. All Residents and Resident #10 included are given care at least every 2 hrs. The in-service notified Nursing Staff / CNA's Resident #10 needs checked more frequently between the hours of 11am and 1pm. 2. DON and/or LPN completed a review of each Resident by reviewing care plans and individual physical observation of Resident's room and modes of physical activities (e.g. wheelchair, geri-chairs, walkers, and mattresses, etc) are in place	3-22-13 3-22-13

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F 323	Continued From page 10 up, low bed, and matt beside bed " 12/17/12 Interventions: " continue PBA, low bed, and matt beside bed. " 1/12/13 Interventions: " continue PBA to wheelchair " 2/4/13 Interventions: " continue PBA while up in wheelchair " The interventions following each fall remained the same with no change in interventions to assist the resident in avoidable falls. The Resident ' s care plan did not provide the intervention of a PBA nor did a facility form titled " nurse aide ' s information " sheet was located in the resident ' s room on inside of the resident ' s closet door and dated 2/20/13. The " nurse aide ' s information " form had documentation that the resident was at risk for falls and required a low bed and a matt beside the bed. On 2/21/13 at 3:00 PM, Resident #10 was observed out of bed and sitting up in his wheelchair. The resident was not wearing a personal body alarm. At 3:40 PM on 2/21/13 NA#5 was interviewed. NA#5 stated that the resident does not have a personal body alarm in use. NA#5 indicated that she uses the nurse aide ' s information sheet inside the closet door to tell her how to care for the Resident. On 2/22/13 at 8:40 AM the Director of Nursing (DON) was interviewed. During the interview the DON indicated that she expected to have falls eliminated or decreased.	F 323	and proper use of fall interventions are in place. 3. Incidents, falls, and fall interventions are reviewed daily per DON and/or LPN. Incidents, falls, and fall interventions will be further reviewed in stand-up 3x's a week to include Therapy, Social Worker, MDS Nurse, Dietary, DON, Administrator, and/or LPN to ensure proper fall interventions are initiated and in place. DON and LPN will audit from list of all residents with fall intervention in place weekly to ensure proper use and correction achieved. This auditing system will be completed weekly x2 months and then monthly. This will be on going. 4. Monthly reviews of fall interventions will be discussed monthly during the QA meeting. The Identified concerns will be addressed with a plan of correction and in-services as necessary per Administrator and DON to achieve and maintain compliance x 3 months and the on going.	3-22-13 3-22-13

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BROOK STONE LIVING CENTER	8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and family interview the facility failed to provide residents with water or other liquids between meals for 2 of 3 (Resident #3, Resident #25) sampled residents for dehydration. Findings include: 1.) Resident was admitted on 10/16/12 that was cognitively intact. The Minimum Data Set (MDS) dated 12/3/12 revealed that the resident ' s functional status was excessive to fully dependant with one assist. The MDS also indicated that the resident had an indwelling foley catheter inserted for urinary retention and was noted to be " sometimes " incontinent of bowel. The Resident was cognitively intact per MDS dated 12/3/12. The Care Area Assessment (CAA) dated 10/23/2012 cited cognitive loss, activities of daily living, urinary incontinence and indwelling foley catheter, psychosocial well being, mood, activities, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and pain. The Resident ' s diagnosis including congestive heart failure, hypertension, diabetes, asthma, chronic obstructive pulmonary disease.	F 327	F 327 1. Resident #25 has water pitcher in room next to bed. Resident #25 makes his need known when he needs/wants fluids. Resident #3 does not have a pitcher of water @ bedside due to order of thickened liquids and order for thin liquids to be given only when monitored/supervised by nursing staff. (Resident will gulp fluids down and choke / aspirate otherwise) Resident #3 makes her needs known and able to ring call light when needing something to drink. Staff also offers fluids approximately q2hrs when in room checking on Resident or providing care. Resident is also offered fluids with each medication pass and meals 2. In-Service of Nursing Personnel was conducted by DON and/or LPN. Nursing staff and CNA's in-serviced on keeping pitchers filled with water and ice. Also to keep fluids within resident's reach.	3-22-13 3-22-13

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F 327	Continued From page 12 During a resident interview on 2/18/13 @ 11:00 AM and 2/19/13 @ 08:30 AM, the resident asked for some water to drink stating that she was thirsty. There was no pitcher of water noted in the room and the resident stated that she doesn't have water at the side of her bed very often. The resident was observed on 2/20/13 @ 2:20 PM in her room, in bed, with her right arm propped up on a pillow, in a semi-fowlers position. Resident was eating a graham cracker. Resident stated that she was thirsty and asked for something to drink. There was no water pitcher in the resident ' s room. There was a half glass of water noted to be on the resident ' s bedside stand but it was out of the residents reach. Upon further observation on 2/20/13 at 3:40 PM, the resident asked for a sip of water. The resident ' s water cup was noted to be on bedside table, empty, and out of residents reach. The first observation of resident ' s foley catheter bag on 2/18/13 at 11:00 AM noted urine in catheter tubing and bag to be a cloudy, milky yellow color. Resident was observed on 2/21/13 at 06:00 AM asleep in her bed with a small blue cup in front of her with a straw but the cup was empty. At 07:00 AM the resident ' s cup on her bedside table was still empty. An interview with the resident ' s family member on 2/21/13 at 01:30 PM revealed that she was concerned that the resident wasn ' t getting enough to drink during the day because " if she isn ' t offered it, she won ' t take it upon herself to do it. " Resident ' s family member stated that there are times when she comes in to visit her sister and there are 2 to 3 juices boxes in front of	F 327	Staff was also notified of coolers at the bedside of Residents with thickened liquids and offering fluids at least every 2 hours and as requested per the Residents. Coolers are filled with thickened liquids per the Dietary department at 10a, 2p, & 8p daily. Nursing staff signs Nourishment sheet indicating snacks and thickened liquids are provided. This service will be on going. 3. Reviews will be completed by Nurses assigned to the units signing sheets provided by Dietary indicating delivery of thickened liquids in coolers delivered to designated Residents with thickened liquid orders. Delivery will be at 10am, 2pm. & 8pm daily. This will be on going.	3-22-13

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F 327	Continued From page 13 the resident but that the resident won ' t drink on her own. Further record review indicated that the resident had been started on an antibiotic course on 12/24/12 for a urinary tract infection. An interview with the Director of Nursing (DON) at 09:01 AM on 2/22/13 indicated that her expectation was that each resident is offered fluids though out the day consistent with the resident ' s plan of care. 2.) Resident #25 was admitted 12/22/10 with diagnoses that included Cerebrovascular Accident (stroke) and Hemiparesis. Review of the most recent Minimum Data Set (MDS) quarterly assessment dated 11/16/12, revealed the resident was cognitively intact for daily decision making. Resident #25 needed extensive assistance for bed mobility. The resident also needed extensive assistance for transfers. On 2/20/13 at 9:00 AM an observation was made of Resident #25' s room, and it was noted that his water pitcher was placed on a dresser out of the resident reach. 2/20/2013 at 11:00 AM another observation was made again of the resident ' s room, and it was noted that the water pitcher was still placed on a dresser out of the resident reach. The resident reported that he had not had anything to drink for a while. 2/20/2013 at 2:46 PM it was observed that the	F 327	4. Weekly reviews of provided fluids and thickened liquids will be audited per DON and/or LPN by visualizing coolers, coolers contents, and pitchers within reach x4 weeks.. Any concerns will be corrected immediately upon discovery. Monthly reviews will be discussed monthly during the QA meeting with Medical Director, Administrator, DON, Dietary, and Therapy. Concerns will be identified and plan of correction will be initiated and put in place with in-servicing as necessary. Review of hydration will be monitored monthly per QA meetings x3 months.	3-22-13

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F 327	Continued From page 14 resident ' s water pitcher was still placed out of reached on the dresser in the room. 2/20/2013 at 2:58 PM two Nursing assistant (NA) went into the room of Resident #25. At 3:15 pm the two NAs came out of the room but the water pitcher was still on the dresser out of the resident ' s reach. 2/20/2013 an interview was conducted with NA #3 at 3:15PM after exiting the resident ' s room, in which she revealed that his pitcher should have been placed on his bedside table instead of on the dresser out of reach. An interview with NA #1 at 3:2PM revealed that she had filled the pitcher with ice and placed it on the dresser at 1:30PM. NA #1 indicated that the resident was particular about things. NA #1 did not say why the pitcher was placed out of the resident ' s reach. On 2/21/13 during an interview at 4:00PM the Director of Nursing reported that she expected the water pitcher to be in reach for the resident to utilize.	F 327		

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

March 28, 2013
NC Department of Health and Human Services
Division of Facility Services
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711

Dear Ms. Jennings:

Enclosed you will find a revised plan of correction for the survey conducted in our facility from 02/18/13 to 02/22/13.

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

Sincerely,

Janice Mallard

Janice Mallard
Administrator

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ MAR 27 2013	03/06/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a automatic sprinkler system(bedroom closets are not sprinkled. Only bedroom closets on 300 hall are sprinkled).. The deficiencies determined during the survey are as follows:	K 000	K 029 1. Maintenance Director has installed self closing devices on the old medical records room and the activity director's office. 2. Maintenance Director has checked all other rooms to ensure rooms are not used as a storage room and do not need self closing devices. (no other rooms were found) 3. Maintenance Director and Administrator will monitor 1x week for 1 month and then once a month for 1 quarter to ensure no rooms need self closing devices due to being used for storage. 4. Administrator and Maintenance Director will review quarterly in QA meetings to ensure no rooms need self closing devices on doors due to rooms being used for storage.	3-27-13 3-27-13 3-27-13 3-27-13
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: door to old medical records room and activity director office is not self closing(being used for storage).	K 029	K 038 1. Maintenance Director has replaced door handle on manager office in kitchen with handle to make exit readily accessible at all times. 2. Maintenance Director has checked all doors in facility to ensure no other handles requiring two motion's of hand to open door to exit egress are in place. (There were no other findings) 3. Maintenance Director will monitor weekly for 1 quarter to ensure all exits (door handles) are readily accessible at all times. 4. The Maintenance Director and Administrator will review monthly in QA meetings to ensure all exits (door handles) are readily accessible at all times.	3-27-13 3-27-13 3-27-13 3-27-13

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

Julie Mallard | Administrator | 3-26-13

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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K 029	Continued From page 1 42 CFR 483.70(a)	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: door to mangers office in kitchen require two motion's of hand to open door to exit egress.	K 038		
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: sprinkler heads in laundry room and at front lobby have excess lent on bulb. Also, facility could not provide proper documentation that a 5 year obstruction investigation has been performed on system.	K 062	K 062 1. Maintenance Director has had contractors to come and clean sprinkler heads in laundry room and at front lobby and they have also conducted a 5 year obstruction investigation on the system. 2. The Maintenance Director also had contractors to clean the remaining sprinkler heads throughout the facility. 3. Maintenance Director and Administrator will monitor 1x week and then 1x monthly for 1 quarter to ensure sprinklers are clean and contractors have added to our files for a 5 year obstruction investigation to be completed on a 5 year basis. 4. The Maintenance Director and Administrator will review monthly in QA meetings to ensure sprinklers are clean and to ensure a 5 year obstruction investigation will be completed in 5 years. The next 5 year test should be completed by 3/2018.	3-27-13 3-27-13 3-27-13 3-27-13

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K 062	Continued From page 2 42 CFR 483.70(a)	K 062		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: return vents throughout facility have lent on fusible link. Excess lent would effect the operation of the links/damper's. 42 CFR 483.70(a)	K 067	K 067 1. Maintenance Director has vacuumed and cleaned vents throughout facility to eliminate lent. 2. The Maintenance Director has scheduled vents to be cleaned quarterly to prevent lent build up on the vents. 3. Maintenance Director and Administrator will monitor 1x month and then 1x quarterly to ensure vents are free of lent. 4. The Maintenance Director and Administrator will review monthly in QA meetings to ensure maintenance of vents are taking place to keep vents free of lent.	3-27-13 3-27-13 3-27-13 3-27-13
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: the deep fryer was located next to a prep serving area without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069	K 069 1. Maintenance Director has contacted a local welder to make a splash guard for deep fryer and splash guard has been placed on side of deep fryer. 2. Maintenance Director and Dietary Manager will monitor 1x week and then 1x monthly for 1 quarter to ensure splash guard is in place. 3. The Maintenance Director, Administrator, and Dietary Manager will review monthly in QA meetings to ensure splash guard is in place on deep fat fryer.	3-27-13 3-27-13 3-27-13