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	345339	A. BUILDING _____ B. WING _____	C 09/27/2013

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BRIAN CENTER HLTH & REHAB	1306 SOUTH KING ST WINDSOR, NC 27983

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F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and observation, the facility failed to act on a grievance filed at the Resident Council meeting in May 2013. Findings include: A review of the Resident Council meeting minutes from the May 2, 2013 meeting, revealed a complaint of answering call bells. On 9/27/13 at 3:05 PM, in an interview, the Activity Director (AD) stated that she would fill out a concern form. The AD stated that she did not fill out a concern form for the May meeting. The AD stated that she would have addressed the concern the following day during morning staff meeting. The AD stated that she did not have any notes in regard to the Resident Council concern. On 9/27/13 at 3:10 PM in an interview, the Director of Nursing (DON) stated that she had only been employed in the facility a few weeks. The DON stated that she would look for notes on the Resident Council meeting, but she did not have any that she knew of. On 9/27/13 at 4:50 PM, in an interview, the	F 244	1) Resident Council was held on 10-10-13 to provide all residents an opportunity to discuss concerns both from the past and current. A grievance form was completed based on the May 13th Resident Council Meeting related to the concern about slow response to call bells. As the specific source of this concern was not identified the complaint was treated as a general complaint. To assure comprehensive response, minutes from all subsequent Resident Counsel Meetings to date have been reviewed for concerns which may not have been addressed. 2) The Activity Director has been re-educated regarding the process of recognizing concerns, properly documenting, including naming the individual or if it was a group concern, directing concerns to the Administrator for review and following specifically as relates to resident council. 3) Facility staff has also received instruction on the process including writing, submitting and responding or properly directing such concerns. Discussion of the grievance process will be an annual in-service component. New employees will receive instruction on the Grievance process during orientation.	

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

Penny Brown | Administrator | 10-17-2013

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 244	Continued From page 1 Administrator stated that she had no record of the Resident Council meeting concern, and no record of the morning meetings.	F 244	A new Daily Stand-Up Checklist (attached) provides a format for recording such concerns as they are discussed in morning meeting further assuring the resident concern receives a comprehensive response. 4) All concerns and grievances, as well as a review of resident council meeting minutes, will be reviewed by the QAPI committee as a target topic item for three months with trends discussed and presented for interventions. QAPI will determine frequency of these reports and discussion based on findings on an ongoing basis. This corrective action will be fully implemented by October 25, 2013.	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 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. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the facility failed to make call bells accessible to nine of thirty five residents sampled (Res. #12,117,80,4,66,100, 19,7,and 87). Findings included: On 9/23/13 from 2:00 AM until 2:30 AM, during a tour of the facility, call bells were observed either on the floor, or coiled at the foot of the beds of nine residents. 1.A. On 9/23/13 at 2:03 AM, the call bell was observed to be coiled at the foot of the bed. Resident #12 was admitted on 7/14/2009. The quarterly Minimum Data Set (MDS) dated 8/19/13 noted the resident to be moderately impaired for cognition, and had a functional impairment on one side of her body in the upper and lower extremity. Resident #12 was observed to turn on the call bell in her room on 9/27/13 at 3:00 PM.	F 246	F 246 1) Residents 12, 117, 80, 4, 66, 100, 19, 7 and 87 have been assessed with call bells placed within easy reach. 2) All residents have the potential to be affected by call bell positioning. Through Ambassador Rounds, daily nurse rounding, and enforcement of the call bell policy, residents will have their call bells at easy reach.	

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F 246	Continued From page 2 B. On 9/23/13 at 2:04 AM, the call bell was observed to be coiled at the foot of the bed. Resident #117 was admitted on 7/12/13. The admission MDS dated 7/19/13 noted the resident was cognitively intact and had a limitation of the lower extremity on one side. Resident #117 moved around throughout the facility in a wheel chair. On 9/26/13 at 2:30 PM Resident #117 demonstrated turning on her call bell. C. On 9/23/13 at 2:10 AM, the call bell was observed on the floor. Resident #80 was admitted on 11/12/12. The quarterly MDS dated 8/9/13 noted that Resident #80 was cognitively intact and had no impairment of extremities. In an interview on 9/27/13, at 3:20 PM, Resident #80 indicated that he could use the call bell whenever he needed to. D. On 9/23/13 at 2:13 AM, the call bell was observed on the floor. Resident #4 was admitted on 8/17/12. The annual MDS dated 8/22/13 noted that the resident was cognitively impaired and needed extensive assistance for all Activities of Daily Living (ADLs). The MDS also noted that Resident #4 had no impairment of extremities. E. On 9/23/13 at 2:14 AM, the call bell was observed on the floor. Resident #66 was admitted on 2/22/13. The quarterly MDS dated 8/19/13 noted that the resident was severely impaired for cognition, and had a limitation in her upper extremity on the left side. On 9/27/13 at 11:00 AM, the resident was given the call bell and did turn on the call bell. F. On 9/23/13 at 1:59 AM, the call bell was observed on the floor. Resident #100 was admitted on 3/15/13. The quarterly MDS dated	F 246	3) Facility staff has been in-serviced on the proper placement of call bells which are to be kept within easy reach of residents in order to promote safety, comfort and rights of residents. Nurses have been in-serviced to make rounds at least once per shift at random times to validate proper call light placement. New employees will be provided information on proper placement and expectations regarding quality and timing of response. During Ambassador Rounds, appropriate call bell placement will be validated. On at least a weekly basis, each resident who is able to be interviewed will be asked to comment on his/her access to his/her call bell as well as any comments about response quality or response time. The Administrator will collect these responses in order to identify and act upon any trends that may emerge. 4) Data collected through this corrective action will be presented to QAPI monthly X 3 months with a determination by the committee at that point to guide ongoing efforts. This corrective action will be fully implemented by October 25, 2013.	

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6/21/13 noted Resident #100 was cognitively intact and impaired on one side for both upper and lower extremity. The charge nurse on the 11-7 shift confirmed, on 9/23/13 at 3:15 AM, that Resident #100 could use the call bell, and Nurse Aide (NA)#1 on the 7-3 shift confirmed, on 9/23/13at 8:57 AM, that Resident #100 could use her call bell.

G. On 9/23/13 at 2:00 AM, the call bell was observed on the floor. Resident #19 was admitted on 3/10/10. The quarterly MDS dated 8/22/13 noted that Resident #19 was cognitively impaired, used a wheel chair, and had no upper extremity impairment. The 11-7 shift charge nurse stated, on 9/23/13 at 3:15 AM, that Resident #19 could use his call bell, and this was confirmed on 9/23/13 at 8:57 AM by NA #1 who is on the 7-3 shift.

H. On 9/23/13 at 2:06 AM, the call bell was observed on the floor. Resident #7 was admitted on 9/20/2012. The Quarterly MDS dated 8/15/13 noted that Resident #7 was cognitively intact, and had an impairment of one side in the lower extremity.

I. On 9/23/13 at 2:01 AM, the call bell was observed coiled at the foot of the bed. Resident #87 was admitted on 7/24/2012. The annual MDS dated 7/24/13 noted the resident was moderately impaired for cognition, and had no impairment of his extremities. On 9/24/13 at 2:00 PM, Resident #87 stated that he could turn on his call bell when

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F 246	Continued From page 4 he needed it. On 9/23/13 at 2:47 AM, in an interview, NA#4 stated that she would make rounds at 11PM, 2AM, 4AM, and 6AM on each resident. During the rounds, the NA would change incontinent briefs, position the resident in bed, empty Foley catheter bags, ask if the resident wanted water, and check ostomies. At 5 AM the NA would pass ice. When asked as to when the call bells were checked (referring to placement), NA #4 stated that the call bells were answered when the buzzer went off. When asked as to whether or not there was a problem with call bells falling off of beds, or being pushed out of reach in the night, NA#4 stated " no. " On 9/23/13 at 3:05 AM, in an interview, NA#3 stated that she would check to see if residents were wet during her rounds, she would turn them, make sure call lights were connected and if they needed anything. When asked about call bells, NA #3 stated that sometimes call bells were displaced out of reach of residents in the night. She reported that she would usually hook the call bell on the resident ' s bed covers or side rails if the resident moved around a lot, to prevent it from falling on the floor. In an interview on 9/23/13 at 3:15 AM, Nurse #4 stated that residents were checked every 2 hours on the 11-7 shift. An assigned task would be completed by staff during each round. Nurse #4 stated that residents would be checked on rounds for proper positioning, changing briefs, making sure the call bell was attached to something and within reach of the resident, beds were low to the ground for those residents who were falls risks, and that the head of the bed would be elevated	F 246		

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F 246	Continued From page 5 for residents with feeding tubes. Nurse #4 stated that her expectation in regard to placement of call bells would be that the call bell should be within reach of the resident at all times, even if the resident was unable to use it.	F 246	F 250	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, nurse practitioner, physician and staff interviews, the facility failed to obtain a psychiatric consultation as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #46). The findings included: 1) Resident #46 was re-admitted to the facility on 7/20/10 from a hospital with multiple diagnoses including severe ischemic cardiomyopathy (a condition that occurs when the heart muscle is weakened), diabetes, profound hearing loss, history of stroke, and organic brain disease with behavioral symptoms. A review of the resident ' s medical record revealed she had been seen by the psychiatry Nurse Practitioner (NP) for a Psychiatric Initial Evaluation on 2/7/13 due to worsening aggressive	F 250	1) Resident #46 was seen by the psychiatrist on 10/3/2013 as had been recommended by the Psychiatric Nurse Practitioner. Recommendations included in that consult have been implemented. 2) All residents have the potential to be affected by recommendations written by outside providers for further outside services. To assure orders written by outside providers are fully implemented, documents resulting from outside provider services will be placed in the "Outside Consults" box at the nurse's station. A Nurse is assigned to review and implement recommendations, orders and other potential changes that may be included on these documents. Once reviewed and all data verified, the Consult form is placed in the clinical record. On a daily basis, the previous day's appointments for outside services will be matched against documents returned from such appointments to assure the facility has received and acted upon resulting recommendations. Discrepancies will be immediately resolved.	

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F 250	Continued From page 6 behavior, anxiety, bizarre behavior and irritability. The diagnoses included: dementia with behavioral disturbance related to mood disorder. The resident was receiving 0.25 milligrams (mg) haloperidol (an antipsychotic medication used for the treatment of psychosis) given once daily at bedtime. The NP recommendations included increasing haloperidol 0.25 mg to twice daily dosing. The haloperidol was increased by the physician as recommended on 2/8/13. The psychiatry NP conducted a follow-up visit on 5/2/13. The NP recommendations included the continuation of 0.25 milligrams (mg) of haloperidol given at bedtime. No changes in medication were made by the physician at that time. The resident continued to receive haloperidol 0.25 mg twice daily. A review of Resident #46 ' s July 2013 Monthly Physician Orders revealed her treatment regimen included the following psychotropic medications: 15 mg mirtazapine (an antidepressant medication which is occasionally selected for its potential to stimulate appetite) given as one tablet by mouth daily with the indication noted as " appetite stimulant " ; and 0.5 mg haloperidol given as 1/2 tablet (0.25 mg) twice daily with the indication noted as " mental disorder. " A review of the resident ' s July 2013 Behavior/Intervention/Outcome Medication Monitoring Forms for haloperidol and mirtazapine was completed. One event (occurrence) of behavior was noted on 7/24/13. No other behaviors were reported on the Medication Monitoring Forms for July 2013. A review of Resident #46 ' s quarterly Minimum	F 250	3) Nurses have been in-serviced on the process including where to place consult documents. As new applicable employees are hired, the process will be reviewed during orientation. 4) For 60 days, the DON will review the prior day's appointments (Monday-Friday) and match the paperwork and follow up documents to assure completion. Any discrepancies will be resolved at that time. The findings of this audit portion of the corrective action will be documented and brought to QAPI monthly for 2 months with a decision made by the committee for further intervention or review. This corrective action will be fully implemented by October 25, 2013.	

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Data Set (MDS) dated 7/29/13 revealed staff assessed the resident as having severely impaired cognitive skills for daily decision making. No behaviors or rejection of care were indicated. The resident required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene with supervision only for locomotion and eating. A handwritten note was made on the MDS Section C Assessment dated 7/29/13 which read: " (Resident ' s Name) hearing aide is missing and she is unable to complete BIMS (Brief Interview for Mental Status) and pain assessment. She exhibits ST (short-term) memory impairment and unable to follow instructions (written) 5 minutes after given. She currently has severely impaired decision-making skills. "

A review of the Nursing Daily Skilled Summary dated 7/29/13 noted the resident ' s emotional status as: alert, anxious, confused, restless, and agitated. A Nurse ' s Note dated 7/29/13 indicated: " Spoke with (resident ' s physician) re: resident very agitated, rolling about facility yelling about wanting to go home. Have order received. "

A review of Resident #46 ' s medical record revealed the resident ' s physician wrote the following orders on 7/29/13: 1) Discontinue previous haloperidol order; 2) 0.5 mg haloperidol given as one tablet by mouth every morning; 3) 1 mg haloperidol given as one tablet by mouth once daily at 4:00 PM; and 4) 1 mg lorazepam (an anti-anxiety medication) given as one tablet by mouth three times daily as needed for anxiety.

A review of the Nurses ' Notes dated 8/4/13 stated in part, " Resident noted with increased

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F 250	Continued From page 8 agitation. PRN (as needed) Ativan (lorazepam) given. Results pending. " A review of the Physician ' s Progress Notes dated 8/4/13 was completed. The note stated in part, " A lot of behavioral issues over past 2 weeks. (Resident ' s Name) is getting aggressive. " On 8/4/13, the physician wrote an order for 5 mg olanzapine once daily. Olanzapine is an antipsychotic medication which may be used for acute mania or agitation associated with bipolar disorder or schizophrenia. On 8/4/13, a physician ' s order was also written for " Psychiatry appointment for worsening in mental function. " A review of the resident ' s August 2013 Behavior/Intervention/Outcome Medication Monitoring Forms for mirtazapine and haloperidol was completed. Two events of confusion/delirium were noted on 8/4/13. No other behaviors were reported on the Medication Monitoring Forms for August 2013. A review of the resident ' s August 2013 Medication Administration Record (MAR) revealed the resident received one dose of lorazepam on each of the following dates: 8/3/13, 8/4/13, 8/6/13, 8/7/13, 8/19/13, and 8/20/13. Further review of Resident #46 ' s medical record revealed there was no documentation indicating the resident had been seen for a psychiatry referral ordered by the physician on 8/4/13. An interview was conducted with Nurse #2 (a Unit Coordinator) on 9/25/13 at 3:35 PM. Nurse #2 reviewed Resident #46 ' s medical record and	F 250		

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acknowledged there was no documentation on the resident ' s chart indicating a psychiatric appointment had been completed since the physician requested one on 8/4/13.

A follow-up interview was conducted with Nurse #2 on 9/25/13 at 4:17 PM. At that time, Nurse #2 reported she had received a call back from the psychiatry medical group which confirmed Resident #46 had not been seen by the Nurse Practitioner (NP) in either August or September 2013. Upon inquiry, Nurse #2 outlined the process for obtaining a psychiatry appointment. The nurse reported that the Social Worker (SW) would be made aware of an order for a psychiatry referral and would then be responsible for compiling a list of residents who needed to be seen by the NP. The list would go to the NP when he came in, a Progress Note would be written for each resident seen, the resident ' s Primary Care Physician would review the Progress Note for recommendations and the physician would write any new orders needed. Once signed by the physician, the Unit Assistant would file the Progress Note in the resident ' s medical record.

An interview was conducted with the facility ' s Social Worker (SW) on 9/26/13 at 10:53 AM. During this interview, the SW indicated the facility contracted with a psychiatry provider (a Nurse Practitioner) to provide consultative services for residents. She stated the provider came to the facility twice a month to see residents. The SW indicated nursing staff would initiate the psychiatry referral process by completing an " In-House Communicator " (in paper form) and passing it along to the SW. The SW stated she would provide a list of new and follow-up

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residents who needed to be seen by the provider. After each psychiatry visit, the provider would send back his evaluation and recommendations to the SW and she would give these to the Director of Nursing (DON) and the Charge Nurse. The SW indicated that Resident #46 was on the list of residents needing to be seen by the psychiatry provider on 8/15/13. The SW reported she would always get an evaluation back on the residents after they had been seen. However, she acknowledged she did not receive one for Resident #46. When asked if there was a follow-up process in place to ensure all residents needing a psychiatry appointment were seen, the SW stated, " I know exactly what you ' re saying. He (the psychiatry NP) usually sees everybody on the list. I ' m thinking it was due to her hearing. " Upon inquiry, the SW stated she did not believe there was documentation indicating a reason why the psychiatry service was not provided for Resident #46 on 8/15/13. When asked if the physician had been notified a psychiatry consultation had not been done, the SW stated, " I ' m not sure. "

A telephone interview with the facility ' s consultant psychiatry NP was conducted on 9/26/13 at 11:20 AM. The NP reported that he had seen Resident #46 in February 2013 and most recently in May 2013. He was not aware a physician referral had been made for a psychiatry appointment on 8/4/13 and the NP confirmed he had not seen the resident for this referral. The NP indicated he came to the facility on the first and third Thursday afternoon of each month. In reviewing the process of working with the facility, the NP stated a list of residents who needed to be seen at the facility was sent to his office prior to each visit. The NP indicated that after a resident

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was seen, he would fax a Progress Note to the facility to the Social Worker ' s attention. The NP added that he has worked with the facility to streamline the referral process because on occasion these notes have been missing out of the charts. When asked if there was a follow-up process in place to ensure psychiatry referrals were not missed, the NP stated this had not been discussed. The NP then indicated he needed to work with the facility to figure out a more specific way to: 1) identify when a psychiatry referral made; and 2) document when a referral was not completed, along with the reason why.

A telephone interview was conducted with Resident #46 ' s physician on 9/26/13 at 3:30 PM. The physician reported Resident #46 exhibited increased behaviors over the past 1-2 months, which had prompted him to increase her haloperidol and initiate olanzapine and lorazepam. The physician stated he was aware the resident ' s hearing aide had been lost sometime in July and acknowledged her profound hearing loss (uncorrected) may have contributed to the increase in behaviors. The physician noted that he had made a referral to psychiatry on 8/4/13 for an evaluation of the resident ' s behaviors. Upon inquiry, the physician indicated he was not aware that Resident #46 had not been seen by psychiatry for this referral.

Upon request, an interview was conducted with the facility ' s Administrator and Corporate Nurse Consultant on 9/26/13 at 3:55 PM. During this interview, it was noted by both the Administrator and Nurse Consultant that the facility was aware of the problem of consults being missed and was in the process of addressing this issue.

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F 281 F 281 SS=D	Continued From page 12 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow a physician ' s medication order for 1 of 3 residents (Resident #106) reviewed for the medication pass administration; and failed to monitor a resident ' s weekly weights as ordered by the physician for 1 of 5 sample residents receiving a diuretic (Resident #93). The findings included: 1) Resident #106 was admitted to the facility on 9/5/13 with diagnoses including gastro-esophageal reflux disease and urinary urgency. A review Resident #106 ' s medical record revealed the resident ' s admission medication orders dated 9/5/13 included an order for oxybutynin 5 milligrams (mg) with instructions to give 1 tablet three times daily. The order was not written for the extended release (ER) formulation of oxybutynin. Oxybutynin is a medication used to treatment symptoms such as urgency, frequency, or leakage associated with an overactive bladder. On 9/13/13, a telephone order was received to change the route of administration for all medications from NG (nasogastric) tube to PO (by mouth).	F 281 F 281	1) Resident #106 is incorrectly identified. Resident #106 was discharged from the facility on 6/28/2013. However, the resident in room # 106, who is labeled on the Stage 2 Sample Resident List as resident #126 matches the situation described for this alleged deficiency. 2567 labeled resident #106 (resident #126 hereafter) has orders clarified for his medication dose and formulation. The correct medication is in the medication cart. Resident #93 has orders for weekly weights. Weights are recorded on the Vital Signs & Weights Flow Sheet which is maintained in the Weight Book during the month of recording then placed in the resident's clinical record at the end of each month with a new Flow Sheet started. The order for the non-monthly weight is also included on the MAR to alert the nurse to access the weight on at least a weekly basis and use it to assess the resident's status.	

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F 281	Continued From page 13 Review of the September 2013 Medication Administration Record (MAR) revealed Resident #106 had been given 5 mg oxybutynin ER once daily from 9/6/13 through 9/26/13 (versus immediate release oxybutynin 5 mg three times daily as ordered). The September 2013 MAR indicated oxybutynin 5 mg was to be given three times daily. However, 8:00 AM was the only administration time listed on the MAR. During an observation of a medication pass administration on 9/26/13 at 8:30 AM, Nurse #3 was observed preparing and administering medications to Resident #106. The medications administered included one tablet of oxybutynin 5 mg ER. During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON stated an investigation would be conducted to look into the identified medication errors. The DON reported her expectation was that the right resident, medication, dose, dosage form and route of delivery would be verified during medication administration to ensure accuracy. The DON stated completion of a medication error report was part of facility ' s established process when a medication error was identified and a general in-service would be provided as a reminder to try to avoid these things from happening in the future. 2) Resident #93 was re-admitted to the facility from a hospital on 8/7/13 with diagnoses including: heart failure, hypertension, and diabetes. The resident ' s admission medications included the following: 40 mg furosemide (a diuretic) given twice daily. A review of the resident ' s medical record included a Nursing	F 281	2) As all residents have the potential to be affected by missed or incorrectly transcribed orders and/or for omission of non-routine weights and vital signs, a complete review of current physician's orders compared to MAR and medications in the cart, has been conducted. Each is verified as the order matching the transcribed instructions and the medications available to be administered in the cart. For all Physicians' orders that include weights or vital signs specific to a medication administration, those instructions have been added to the MAR with a note specifying what is required. For these residents a vital sign log has been added to the residents' section of the MAR for recording where it is appropriate. Weights will continue to be recorded in the Weight Book with the reminder alert printed on the MAR.	

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F 281	Continued From page 14 Admission Intake form dated 8/7/13 which indicated the resident had, " mild edema noted in LE (lower extremity) non-pitting edema (fluid retention). " A review of the Vital Signs and Weight Flow Sheet for Resident #93 indicated his weight upon admission on 8/7/13 = 223.4 pounds (#). Lower extremity edema was documented in the Nursing Daily Skilled Summaries dated 8/8/13 and 8/13/13. On 8/13/13, a physician ' s telephone order was received to obtain weekly weights for Resident #93. The order included instructions to notify the physician of a weight gain of 3-5 pounds in one week. A review of the August 2013 Medication Administration Record (MAR) revealed this order had been transcribed onto the August 2013 MAR. Resident #93 ' s 8/14/13 weight of 213.4# was recorded on both the August 2013 Vital Signs and Weight Flow Sheet and the August 2013 MAR. No additional weights for Resident #93 were documented on either the August 2013 MAR or the resident ' s Vital Signs and Weight Flow Sheet in the medical record. A review of the Nursing Daily Skilled Summary dated 8/21/13 revealed the resident had lower extremity edema. A review of Resident #93 ' s medical record, which included a Vital Signs and Weight Flow Sheet and September 2013 MAR, revealed that no weekly weights had been recorded for September 2013. Further review of the resident ' s medical record revealed a medical nutrition therapy note from the	F 281	3) The weight book will be monitored during morning clinical meeting with a list of weights due that day prepared and presented to the assigned team member. That team member will return completed weight assignments to the DON or designee by the end of the shift. Audit for weights and vital signs will be conducted daily. Any discrepancies identified will be provided to the DON for review and follow up as appropriate. Licensed Nurses, CNAs, the Dietary Manager and Restorative staff have been in-serviced on this corrective action. New employees within those designations will be informed of this process during orientation. 4) Data accumulated during this audit will be reviewed at QAPI for the next 60 days for recommendations regarding further intervention, education or action. This corrective action will be fully implemented by October 25, 2013.	

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consultant dietitian dated 9/23/13 which documented his September 2013 monthly weight = 181.8#. No edema was indicated at that time. The dietitian requested a recheck on the resident ' s weight, " due to possibility of error. " She also recommended monitoring of his weights.

An interview was conducted with Nurse #1 on 9/25/13 at 1:52 PM. Upon inquiry, the nurse indicated residents ' weekly weights were documented on a flow sheet (the Vital Signs sheet) in the residents ' medical record.

An interview was conducted with Nurse #2 on 9/25/13 at 3:35 PM. Nurse #2 stated that weekly weight records were kept on the Vital Signs Flow Sheet and that the Dietary Supervisor also kept documentation of these weights.

A review of the weight records provided by the Dietary Supervisor revealed 3 weights had been recorded in August on the Weekly Weight Tracking Program:
8/5/13 weight = 201.6# (Resident #93 was readmitted to the facility on 8/7/13 with an admission weight noted as 223.4#)
8/12/13 weight= 197.8# (8/14/13 weight = 213.4# was documented on the Vital Signs and Weight Flow Sheet)
8/19/13 weight = 197.2#
The September 2013 Monthly Weight records provided by the Dietary Supervisor noted the resident ' s monthly weight = 181.8 # (the specific date of the monthly weight was not indicated on the record). Although the Weekly Weight records provided by the Dietary Supervisor listed Resident #93, they revealed no weekly weights had been recorded to date in September 2013.

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F 281	Continued From page 16 An interview with the Corporate Nurse Consultant was conducted on 9/26/13 at 11:00 AM. The nurse consultant reviewed weight records from the resident ' s previous admission which revealed a 7/8/13 weight of 184.6#. The consultant indicated the July 2013 weight likely represented the resident ' s usual weight (without edema) and approximated the 9/13 monthly weight of 181.8#. Upon further review, the nurse consultant acknowledged the documentation for Resident #93 ' s weekly weights from 8/13/13 (the date weekly weights had been ordered) through 9/26/13 was incomplete.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to ensure suprapubic catheter tubing was secured for 1 of 1 residents. (Resident # 22). Findings include: Findings include: 1. Resident # 22 was admitted to the facility on	F 315	1) Resident #22 has a catheter tubing strap applied and validated daily for safely and comfortably securing his suprapubic catheter. 2) All residents with indwelling catheters have the potential to be affected by lack of securing catheter tubing. Residents with indwelling catheters have been identified and the list is updated during clinical meeting. CNAs are charged with assuring a securing device is appropriately placed on each resident. Nurses have been assigned a double check to validate placement.	

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F 315	Continued From page 17 9/10/12 with diagnosis of paraplegia. A review of the quarterly Minimum Data Set (MDS) assessment of 6/18/13 revealed Resident # 22 was moderately cognitively impaired and was able to understand others and make self understood. Resident # 22 required total care from staff with the exception of feeding self after set up. Resident # 22 had a suprapubic catheter due to paraplegia and urinary retention. A review of physician's orders for 9/24/13 revealed "anchor cath (catheter) to prevent excessive tension." A review of Resident # 22's care plan for the indwelling suprapubic catheter, dated 9/24/13, revealed the intervention: "Anchor catheter to prevent excessive tension." During an observation of a sacral dressing change for Resident # 22 on 9/25/13 at 2:05 PM, the suprapubic catheter tubing was noted without a securement device to prevent pulling or tension. During an interview on 9/26/13 at 2:46 PM, the Treatment Nurse stated she did not know why the resident did not have a catheter strap in place. During an interview on 9/26/13 at 3:20 PM, Resident # 22 stated, "Sometimes they (staff) put a strap on and sometimes they don't." During an interview on 9/27/13 at 2:15 PM, NA # 5 stated she bathed Resident # 22 on 9/26/13. NA # 5 stated she did not notice he did not have a catheter strap in place. NA # 5 stated, "We usually do use straps to secure catheter tubing." During an interview on 9/27/13 at 2:20 PM,	F 315	3) CNAs and Nurses have been provided additional instruction of the proper application of catheter securement devices. Nurses have been in-serviced on the requirement of validating that the device is in properly in place each day. 4) Data from daily checks for secured tubing will be provided to the DON for tracking and trending and presented at QAPI for a period of 60 days. QAPI will determine the monitoring process going forward. This corrective action will be fully implemented by October 25, 2013.	

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F 315	Continued From page 18 Resident # 22 stated he had a catheter strap in place. Resident # 22 stated, "I have not had a catheter strap for awhile until they put one on me yesterday afternoon." During an interview on 9/27/13 at 3:40 PM, the Director of Nursing (DON) stated, "Staff are aware to use a securement device with catheters. If they see that a resident does not have one, they should put one on the resident and / or at least question why they don't have one."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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.	F 329	F 329 1) Resident #46 has had potassium level addressed by physician by discontinuing the potassium supplement. The physician will continue to monitor and order additional blood work and/or medication adjustments as indicated. Resident #55 is routinely having vital signs monitored as ordered with a Vital Signs & Weights Flow Sheet included in the MAR for recording. The MAR has had a statement added to alert the nurse to the need for vital signs to be taken and recorded on the Vital Signs & Weights Flow Sheet. 2) All residents have the potential to be affected by incomplete assessments of laboratory values requesting physician action as well as for missed vital signs that are required to be taken prior to administering certain medications. An audit of ordered labs will be completed covering the last 30 days assuring ordered labs have been appropriately acted upon. Physician's orders have been audited to identify special orders and place those on the MAR with a Flow	

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to monitor laboratory results for a medication for 1 of 5 residents reviewed for unnecessary medications (Resident #46); and failed to monitor a resident ' s vital signs including blood pressure as ordered by the physician for 1 of 1 resident(s) reviewed for dialysis (Resident #55). The findings included: 1) Resident #46 was re-admitted to the facility on 7/20/10 from a hospital with multiple diagnoses including severe ischemic cardiomyopathy (a condition that occurs when the heart muscle is weakened), congestive heart failure (a condition where the heart is unable to provide sufficient pump action and maintain blood flow to meet the needs of the body), diabetes, and hypokalemia (low potassium levels in the blood). A review of Resident #46 ' s laboratory results dated 3/13/13 included the following: serum potassium = 4.2 (normal range 3.5-5.2); and eGFR (estimated glomerular filtration rate may be used as an indication of kidney function) = 27 (normal range is > 59). The resident ' s medications included 60 mg furosemide (a diuretic) given once daily; 12.5 mg spironolactone (a diuretic) given once daily; and 20mEq Klor-Con (a potassium supplement) given once daily. A review of Resident #46 ' s quarterly Minimum Data Set (MDS) dated 7/29/13 revealed staff assessed the resident as having severely	F 329	Sheet for recording the data. These will be reviewed daily by an auditing nurse. 3) Nurses have been in-serviced on the policy and procedure for Laboratory Management which includes guidance for assessing what values require immediate attention by the physician. In-service also included the use of the Vital Signs & Weights Flow Sheet placed within the MAR for recording of weights or vital signs which are directly related to the administration of a specific medication or treatment. 4) The DON will monitor documentation for residents on the list daily (X 5 days per week) for 30 days, weekly ongoing or per the recommendations of QAPI for sustaining compliance. All data will be submitted to QAPI for review for 60 days with recommendations regarding additional interventions as needed. This corrective action will be fully implemented by October 25, 2013.	

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impaired cognitive skills for daily decision making.

A review of Resident #46 ' s laboratory results dated 9/6/13 included the following: serum potassium = 5.9 (normal range 3.5-5.2); and eGFR = 19 (normal range is > 59). The resident ' s medications included 40 mg furosemide (a diuretic) given once daily; 12.5 mg spironolactone (a diuretic) given once daily; and 20mEq Klor-Con (a potassium supplement) given once daily. On 9/6/13, a telephone order was received from the resident ' s physician to decrease the furosemide to 20 mg given once daily. No other medication changes were made at that time. The laboratory results dated 9/6/13 were initialed by the physician (the initials were not dated).

An interview was conducted with the Director of Nursing (DON) on 9/26/13 at 9:51 AM. During this interview, Resident #46 ' s elevated potassium lab result was discussed. The DON reported she would have expected an elevated potassium laboratory result to have been called in to the physician for further instructions or orders. Once the physician was notified, the nurse would have been expected to make a note on the lab form and write, " See new orders, " with the date and nurse ' s initials so the facility staff would know it had been addressed. The nurse who called the physician would also have been responsible to write the new orders and to schedule repeat laboratory testing as instructed by the physician.

A telephone interview was conducted with Resident #46 ' s physician on 9/26/13 at 3:30 PM. After review of the 9/6/13 potassium laboratory result and the current order for 20mEq potassium daily, the physician stated, " That needs to be

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discontinued obviously. If I would have been notified (of the potassium result) I would have stopped it. " At the end of the interview, the physician requested a facility staff nurse be put on the telephone to receive an order. A telephone order was recorded by a staff nurse on 9/26/13 to discontinue the potassium supplement.

2) Resident #55 was admitted to the facility on 5/22/12 with multiple diagnoses including: end-stage renal disease (with the resident receiving dialysis), diastolic congestive heart failure (which refers to the decline in the performance of one or both ventricles of the heart when the heart is relaxing and filling with incoming blood that is being returned from the body), hypertension (high blood pressure), respiratory failure, and diabetes.

Admission medications for Resident #55 included the following: 10 mg amlodipine (a blood pressure medication) given as one tablet once daily and 25 mg carvedilol (a blood pressure medication which may also affect heart rate) given as one tablet twice daily. Physician orders written on 6/25/12 included instructions to check the resident ' s blood pressure, pulse, respirations and temperature (vital signs) every shift (three times daily).

A review of the quarterly Minimum Data Set (MDS) assessment dated 7/10/13 revealed Resident #55 was cognitively intact for daily decision making skills. There were no behaviors or rejection of care noted.

A review of Resident #55 ' s August 2013 Medication Administration Record (MAR) revealed that with the exception of 7 shifts during

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the month, vital signs were initialed as completed each shift (3 times a day) during the month of August. Further review of the August 2013 MAR revealed the vital sign results were recorded once daily for two days in August. A review of Resident #55 ' s medical record included a Vital Signs and Weight Flow Sheet. The Flow Sheet revealed vital signs were recorded once daily for 3 days during the month of August 2013.

A review of the September 2013 Medication Administration Record (MAR) revealed that with one exception, vital signs were initialed as completed each shift (3 times a day) to date in September 2013. Further review of the September 2013 MAR revealed no vital sign results were recorded for the month. A review of Resident #55 ' s medical record included a Vital Signs and Weight Flow Sheet. The Flow Sheet revealed vital signs were recorded once daily for 8 days during the month of September.

An interview was conducted with Nurse #1 on 9/25/13 at 1:52 PM. Upon inquiry, the nurse indicated that if there was an order for vitals to be taken every shift, the documentation of the vital sign results should be on the MAR.

An interview was conducted with Resident #55 on 9/25/13 at 3:23 PM. During the interview, the resident noted that the facility ' s staff often checked her blood pressure in the late morning. When asked if her blood pressure was checked at any other time of the day while she was at the facility, Resident #55 stated it was not. She indicated her blood pressure was not checked more than once daily.
An interview was conducted with Nurse #2 on 9/25/13 at 3:35 PM. Nurse #2 stated that results

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F 329	Continued From page 23 of vital signs would be documented on the Vital Signs Flow Sheet in the resident ' s chart. An interview was conducted with the facility ' s Administrator on 9/25/13 at 4:26 PM. During the interview, the administrator was asked if Resident #55 was oriented and reliable in providing accurate information. The administrator stated, " Yes, I think so. Anytime I talk with her she is. " An interview was conducted with the Director of Nursing (DON) on 9/26/13 at 9:51 AM. Upon inquiry, the DON stated if vital signs were ordered every shift, she would expect them to be done every shift. She noted that if the vital signs coordinated with a medication, the vital sign results may be recorded on the MAR as a way of looking at how the blood pressures were running, for example. When asked if she would then expect results of the vital sign checks to be recorded every shift (in addition to the nurses ' initials indicating completion of the vital sign check), the DON stated, " absolutely. " A review of the facility ' s Protocol/Guidelines for Documentation of Weights and Vital Signs dated 9/27/13 was completed. The protocol indicated vital signs would be recorded in the Vital Signs Flow Record in the resident ' s medical record.	F 329		
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	F 332	F 332 1) Resident #106 is incorrectly identified. Resident #106 was discharged from the facility on 6/28/2013. However, the resident who currently resides in room # 106, who is labeled on the Stage 2 Sample Resident List is resident #126, matches the situation associated with this alleged deficient practice. This corrective action will be provided for resident #126. Resident #126 was administered Oxybutynin ER with an attempt to crush the medication prior to administration. The ER formulation cannot be crushed, according to manufacturer's instructions, and the physician's order was written for the non-ER formulation to be given TID while the MAR stated QD. Clarification orders were written for the non-ER formulation of an appropriate dose of Oxybutynin. A medication error	

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F 332	Continued From page 24 by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as evidenced by 4 medication errors out of 29 opportunities, resulting in a medication error rate of 13.7%, for 2 of 3 residents (Resident #106 and Resident #120) observed during medication pass. The findings included: 1a) Resident #106 was admitted to the facility on 9/5/13 with diagnoses including gastro-esophageal reflux disease and urinary urgency. On 9/26/13 at 8:30 AM, Nurse #3 was observed preparing and administering medications to Resident #106. The medications pulled for administration included one tablet of oxybutynin 5 milligrams (mg) ER (extended release). Nurse #3 was observed as she placed the tablet of oxybutynin ER into the pill sleeve for crushing. As she was ready to crush the tablets placed in the pill sleeve, requested the nurse re-check the oxybutynin ER label. Upon request, Nurse #3 checked the oxybutynin ER pharmacy label and confirmed the extended release formulation of oxybutynin was labeled with a warning, " Do not crush. " Nurse #3 then took the oxybutynin ER tablet out of the pill sleeve and administered it in applesauce with the resident ' s other medications that could not be crushed. A review of product information from the manufacturers of oxybutynin ER indicated the extended release tablets must be swallowed whole; do not crush, divide, or chew.	F 332	report was completed for this administration. Resident #126 was administered a Calcium Carbonate tablet after the stop date of 9/13. The MAR was corrected to reflect the discontinuation of the medication. The formula of Calcium Carbonate used was a Tums tablet which is a stock medication. A medication error report was completed based on this administration. Resident #126 was correctly administered docusate sodium tablet. Although the September physician's order form stated to give the medication in liquid form, an order written on 9/13/2013 discontinued all medications given by liquid route and replaced with P.O. (by mouth) formulation. The order has been properly transcribed to the MAR. Resident #120 was administered 5- 500 microgram tables (total 2500) of Vitamin B12 by mouth. The physician's order was for one 2500 microgram tablet to be given by sub-lingual route. The order has been clarified and the correct formulation and dose has been placed in the Medication Cart. A medication error report was generated on this administration.	

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F 332	Continued From page 25 A review of the September 2013 Physician ' s Monthly orders included an order for oxybutynin 5 mg with instructions to give 1 tablet by mouth three times daily. The order was not written for the extended release formulation of oxybutynin. During an interview with Nurse #3 on 9/26/13 at 9:30 AM, the nurse stated, " That ' s not very visible to me with the stamp on the pharmacy card label. " She indicated the " Do not crush " notation on the card label was partially obscured by the pharmacy stamp. During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON stated an investigation would be conducted to look into all of the identified medication errors. The DON reported her expectation was that the right resident, medication, dose, dosage form and route of delivery would be verified during medication administration to ensure accuracy. She indicated that Nurse #3 was " very forthcoming " about the errors observed during the medication pass and physician clarification and/or notification would be done for each of the identified errors. The DON stated completion of a medication error report was part of facility ' s established process when a medication error was identified. She indicated an in-service and education piece would be completed with the employee and a general in-service provided as a reminder to try to avoid these things from happening in the future. 1b) Resident #106 was admitted to the facility on 9/5/13 with diagnoses including gastro-esophageal reflux disease and urgency of urination.	F 332	In each case with residents #126 and resident #120, the nurse who administered was Nurse #3. Nurse #3 has been provided a Medication Management Course including post testing and competency evaluation. To assure continuing compliance with medication pass requirements, Nurse #3 will be observed three additional times at random over the next thirty days. 2) All residents have the potential to be affected by medication errors. The individual corrections extend to all residents and nurses. 3) All nurses are completing the post test for medication administration as well as having a partial med pass observed. As the observation is completed, physician's orders	

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F 332	Continued From page 26 On 9/26/13 at 8:30 AM, Nurse #3 was observed preparing and administering medications to Resident #106. The administered medications included one tablet of 500 mg calcium carbonate given by mouth (crushed). A review of the September 2013 Physician ' s Monthly orders included an order for calcium carbonate 500 mg with instructions to give 1 tablet by mouth three times a day and a ordered stop date of 9/13/13. During an interview with Nurse #3 on 9/26/13 at 9:30 AM, the nurse acknowledged there was a 9/13/13 stop date on the calcium carbonate medication order. During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON stated an investigation would be conducted to look into all of the identified medication errors. The DON reported her expectation was that the right resident, medication, dose, dosage form and route of delivery would be verified during medication administration to ensure accuracy. She indicated that Nurse #3 was " very forthcoming " about the errors observed during the medication pass and physician clarification and/or notification would be done for each of the identified errors. The DON stated completion of a medication error report was part of facility ' s established process when a medication error was identified. She indicated an in-service and education piece would be completed with the employee and a general in-service provided as a reminder to try to avoid these things from happening in the future. 1c) Resident #106 was admitted to the facility on	F 332	will be reviewed against the administration record to assure correct administration, correct dose, correct route, and correct formulation of the medication. Crushed meds will be checked against the current "Do Not Crush" list. Licensed nurses will be provided mandatory in-service on proper medication pass procedures. Based on nurse's post-test results, in-service results and med pass observations, trends, patterns and concerns that emerge will determine the need for additional education, either individually or as a group. An audit has been completed which compares the October physician's orders plus any updated orders since the printing against the MAR. The corrected MARs will be compared to the medications included in the Medication Cart to assure there are no issues of route, formulation, dosage, or time. This audit will be repeated for November and December physician's orders with determination for further follow up at that time.	

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F 332	Continued From page 27 9/5/13 with diagnoses including gastro-esophageal reflux disease and urgency of urination. On 9/26/13 at 8:30 AM, Nurse #3 was observed preparing and administering medications to Resident #106. The administered medications included 1 tablet of 100 mg docusate sodium given by mouth (crushed). A review of the September 2013 Physician ' s Monthly orders included an order for the liquid formulation of docusate sodium 50 mg / 5 milliliters (ml) with instructions to give 10 ml by mouth twice daily. During an interview with Nurse #3 on 9/26/13 at 9:30 AM, Nurse #3 stated, " I guess we need to get that order clarified. " During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON stated an investigation would be conducted to look into all of the identified medication errors. The DON reported her expectation was that the right resident, medication, dose, dosage form and route of delivery would be verified during medication administration to ensure accuracy. She indicated that Nurse #3 was " very forthcoming " about the errors observed during the medication pass and physician clarification and/or notification would be done for each of the identified errors. The DON stated completion of a medication error report was part of facility ' s established process when a medication error was identified. She indicated an in-service and education piece would be completed with the employee and a general in-service provided as a reminder to try to avoid these things from	F 332	4) Med error data is provided to QAPI for review with recommendations made for follow up. This corrective action will be fully implemented by October 25, 2013.	

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F 332	Continued From page 28	F 332		

happening in the future.

2) Resident #120 was re-admitted to the facility on 8/28/13 with diagnoses including anemia and vitamin B12 deficiency.

On 9/26/13 at 8:17 AM, Nurse #3 was observed preparing and administering medications to Resident #120. The administered medications included 5 tablets of vitamin B12 500 micrograms (mcg) tablets for a total of 2500 mcg given by mouth.

A review of the September 2013 Physician ' s Monthly orders included an order for the sublingual (under the tongue) formulation of Vitamin B12 with instructions to give one 2500 mcg tablet once daily.

An interview was conducted with Nurse #3 on 9/26/13 at 10:23 AM. Upon request, the nurse pulled the bottle of Vitamin B12 tablets given to Resident #120 from the medication cart and compared the bottle with the Medication Administration Record (MAR). Nurse #3 confirmed the Vitamin B12 tablets were not labeled as " sublingual " tablets. She also acknowledged the MAR indicated sublingual Vitamin B12 tablets had been ordered by the physician.

During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON stated an investigation would be conducted to look into all of the identified medication errors. The DON reported her expectation was that the right resident, medication, dose, dosage form and route of delivery would be verified during medication administration to ensure accuracy.

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F 332	Continued From page 29 She indicated that Nurse #3 was " very forthcoming " about the errors observed during the medication pass and physician clarification and/or notification would be done for each of the identified errors. The DON stated completion of a medication error report was part of facility ' s established process when a medication error was identified. She indicated an in-service and education piece would be completed with the employee and a general in-service provided as a reminder to try to avoid these things from happening in the future.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	1) The expired Humalog Mix 50/50 for Resident #15 has been removed and disposed of from the 300 Hall medication cart. The acetaminophen 300mg/30mg combination for resident #84 has been returned as expired to the pharmacy. The Tuberculin PPD injectable solution which was found in the medication storeroom refrigerator opened and undated, has been disposed of. The Zostavax injectable vaccine which had been stored unfrozen was disposed of.	

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F 431	Continued From page 30 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to discard expired medications in 1 of 3 medications carts (the 300 Hall medication cart); failed to label and date medication in the Medication Store Room; and failed to store medication in the Medication Store Room freezer in accordance with the manufacturer recommendations. The findings included: 1) An observation of the 300 Hall medication cart on 9/27/13 at 11:20 AM revealed a vial of Humalog Mix 50/50 insulin with an opened date of 7/25/13 was stored on the cart. The manufacturer ' s product information indicated, "once punctured (in use), vials may be stored at room temperature; use within 28 days." The Humalog Mix 50/50 insulin vial was labeled for Resident #15. A review of Resident #15 ' s September 2013 Physician Orders revealed there was a current order for the insulin to be used on a sliding scale basis (which indicated the insulin was to be used only as needed and that the insulin dose used was dependent on the resident	F 431	2) To assure that no other residents are affected by medication storage issues, all medication storage areas, including medication carts, have been thoroughly inspected with outdated, expired or opened and unmarked medications disposed of. Temperature sensitive medications are now properly stored per manufacturer's guidelines. 3) Nurses have been in-serviced as to facility policy and federal regulations for proper medication storage and administration. To assure proper storage is maintained, a nurse is assigned to inspect medication storage areas, including medication carts, refrigerators and freezers once each 24 hour period. After completing the check, the nurse will sign off the inspection as completed. Any discrepancies are resolved at the time of inspection but also noted on the inspection log, assuring the DON has full knowledge of findings in order to recognize patterns and trends. 4) Data summarized from these inspection logs will be provided to QAPI for 90 days. As data is reviewed, the QAPI committee will guide the process in determining the need for additional interventions and further follow up. This corrective action will be fully implemented by October 25, 2013.	

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F 431	Continued From page 31 ' s blood glucose level). A review of the Blood Glucose Tracking/Sliding Scale Insulin Administration Records for August 2013 and September 2013 revealed 4 doses of insulin were given to Resident #15 after the insulin ' s calculated expiration date of 8/22/13. An interview was conducted with the nurse assigned to the 300 Hall medication cart on 9/27/13 at 11:20 AM. During the interview, Nurse #1 acknowledged the insulin was outdated and should have been discarded 28 days from the date opened. During an interview with the Director of Nursing (DON) on 9/27/13 at 12:00 PM, the DON indicated that once a vial of insulin was opened it should have been dated and discarded in 28 days in accordance with the manufacturer ' s recommendations. The DON reported her expectation was for all expired medications to be removed from the medication cart and a process developed to ensure it was done. 2) An observation of the 300 Hall medication cart on 9/27/13 at 11:20 AM revealed 22 tablets of acetaminophen with codeine 300 mg/30 mg (a combination narcotic pain medication) with an expiration date of 8/31/13 was stored on the cart. A review of Resident #84 ' s September 2013 Physician Orders revealed there was a current order for the acetaminophen with codeine 300 mg/30 mg to be given on an as needed (PRN) basis. A review of the Controlled Medication Utilization Record for Resident #84 revealed one dose of the medication was given to the resident after its expiration date. An interview was conducted with the nurse	F 431		

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F 431	Continued From page 32	F 431		

assigned to the 300 Hall medication cart on 9/27/13 at 11:20 AM. During the interview, Nurse #1 acknowledged the medication was outdated. Nurse #1 reported that if a controlled substance (such as acetaminophen with codeine) was expired, it would need to be removed from the medication cart and stored in the lock box until the DON sent it back to the pharmacy for disposal.

During an interview with the Director of Nursing (DON) on 9/27/13 at 12:00 PM, the DON indicated her expectation was for all expired medications to be removed from the medication cart and a process developed to ensure it was done. She reported that the pharmacy policy to destroy or return controlled substances would need to be followed for the proper disposal of narcotics. The DON indicated she was new to the facility and would need to review the pharmacy policy to ensure compliance.

3) An observation of the Medication Storeroom refrigerator on 9/27/13 at 11:05 AM revealed an open, undated vial of Tuberculin PPD injectable medication (used for skin test in the diagnosis of tuberculosis). The manufacturer ' s product information indicated opened vials should be discarded after 30 days.

During an interview with Nurse #2 on 9/27/13 at 11:05 AM, the nurse indicated the opened vial should have been labeled with the date it was opened on the outside of the vial. Nurse #2 stated this vial would need to be discarded since it was not known when it had been opened.

During an interview with the Director of Nursing (DON) on 9/27/13 at 12:00 PM, the DON

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F 431	Continued From page 33 addressed the normal procedure for storing opened pharmaceuticals such as Tuberculin PPD injectable medication. The DON reported the Tuberculin PPD vials should be dated when opened and discarded in 28-30 days according to the manufacturer ' s recommendations. 4) An observation of the Medication Storeroom refrigerator on 9/27/13 at 11:05 AM revealed an unopened vial of Zostavax injectable medication (a vaccine for shingles) was being stored in the refrigerator. The manufacturer ' s product information indicated, " To maintain potency, Zostavax must be stored frozen between -58o F to +5o F. " During an interview with Nurse #2 on 9/27/13 at 11:05 AM, the nurse indicated the Zostavax vial should have been stored in the freezer as indicated by the product labeling on the box, " Store Frozen. " Nurse #2 stated this vial would need to be discarded since it had not been stored in accordance with the manufacturer ' s specifications. During an interview with the Director of Nursing (DON) on 9/27/13 at 12:00 PM, the DON stated she would have expected the Zostavax vial to have come in to the facility frozen and to have been subsequently stored frozen. She indicated the storage instructions on the product labeling should have been read and the vaccine should have been stored in the freezer as indicated by the manufacturer.	F 431	1) All residents must be administered medication under accepted infection prevention and control guidelines consistent with policy. 2) Each resident is being provided this standard of care consistently.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 34 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 441	3) Nurse #3 has been counseled on proper medication administration, especially as applies to infection prevention. Hand washing technique and requirement for cleaning between patients has been reviewed with Nurse #3. Nurse #3 understands the need to have supplies, including hand sanitizer, on her cart prior to beginning her medication pass and to refill supplies as needed. Nurse #3 has also been in-serviced on the expectation that staff persons who have potential infectious illnesses will report such signs and symptoms and should remain on ave until determined not to be infectious .	

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	345339	A. BUILDING _____ B. WING _____	C 09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING ST WINDSOR, NC 27983

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F 441	Continued From page 35 interviews, the facility failed to follow infection control procedures for hand washing/hand hygiene between residents during the medication administration pass (Resident #120 and Resident #106); and failed to restrict patient contact for 1 of 1 staff members (Nurse #3) with a potentially infectious disease. The findings included: 1) On 9/26/13 at 8:17 AM, Nurse #3 was observed preparing and administering medications to Resident #120. Continuous observation of Nurse #3 as she completed medication administration for Resident #120 and began medication administration for the next resident (Resident #106) revealed she did not wash her hands nor did she use a hand sanitizer between residents. On 9/26/13 at 8:30 AM, Nurse #3 was observed preparing and administering medications to Resident #106. During an interview with the Director of Nursing (DON) on 9/26/13 at 9:51 AM, the DON indicated she would have expected gloves and hand sanitizer to be on the medication carts at all times. The DON stated that she expected nurses to wear gloves for glucometer testing but not necessarily for medication pass. However, the DON stated that she expected nurses to clean their hands between residents during medication pass administration. The DON stated, " I like hand washing but the sanitizer is acceptable. " An interview was conducted with Nurse #3 on 9/26/13 at 10:23 AM. During this interview, the nurse confirmed she did not wash her hands or use hand sanitizer between residents during the medication pass stating, " You ' re right. " The	F 441	4) All staff is being provided in-service on hand sanitizing including both washing and the use of a water free hand sanitizer, and will return demonstrate. In addition, all staff is being provided information on work restrictions based on signs and symptoms of potentially communicable disease. The DON will designate two licensed nurses each day to observe hand sanitizing at random documenting at least 3 opportunities per day each for two weeks with re-education provided immediately as needed. As this corrective action is closely related to the potential for spread of infection, infection surveillance data, as well as audit data from this action will be provided at QAPI with tracking and trending. The QAPI committee will assist in analyzing data and making recommendations for further interventions, education and monitoring. This corrective action will be fully implemented by October 25, 2013.	

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F 441	Continued From page 36	F 441		

nurse noted there was no hand sanitizer on the cart. When asked what she would normally do, Nurse #3 stated, " I ' d have hand sanitizer on the cart and use it. "

2) A review of the facility ' s Infection Prevention Manual for Long Term Care included a Summary of Important Recommendations and Work Restrictions for Personnel with Infectious Diseases dated 2012. The recommendations outlined for viral respiratory infections (acute febrile) included: " Consider excluding from the care of high risk patients (high-risk patients as defined by the ACIP for complications of influenza) or contact with their environment during community outbreak of RSV and influenza. " The anticipated duration of work restriction was noted as, " until acute symptoms resolve. "

On 9/26/13 at 8:15 AM, Nurse #3 was observed during medication pass administration. Upon introduction, Nurse #3 stated, " I might be contagious. Yesterday I was stuffed up and now I ' m coughing up stuff that isn ' t natural. " Nurse #3 added, " I think I picked up a bug from somewhere. " The nurse also indicated, " I never have any gloves on my cart. " The nurse did not obtain gloves from an alternative location during the medication pass observation.

On 9/26/13 at 8:17 AM, Nurse #3 was observed preparing and administering medications to Resident #120. Continuous observation of Nurse #3 as she completed medication administration for Resident #120 and began medication administration for the next resident (Resident #106) revealed she did not wash her hands nor did she use a hand sanitizer between residents. On 9/26/13 at 8:30 AM, Nurse #3 was observed

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F 441	Continued From page 37 preparing and administering medications to Resident #106. On 9/27/13 at 8:20 AM, the Corporate Nurse Consultant reported that Nurse #3 was the facility ' s Staff Development Coordinator and Infection Control Nurse. She stated that Nurse #3 had left work the previous day (9/26/13) with a fever of 101o F. On 9/27/13 at 11:30 AM, an interview was conducted with the facility ' s Administrator, DON, and Corporate Nurse Consultant regarding the facility ' s Infection Control Program. During the interview, the Administrator reported that if a staff member had a potentially infectious disease, he or she would be sent home immediately. She stated the Unit Coordinator had the authority to send a sick staff member home with approval from the Administrator or DON. The DON reported that if a staff member had been sent home with an infectious disease and/or signs/symptoms of coughing, the staff member would need a note from his/her physician to return to work.	F 441		

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

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	345339	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/29/2013

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K 000	INITIAL COMMENTS A. Based on observation on 10/29/2013 the facility is type V(111),fully sprinkled with NC Special Locking on the exit doors.	K 000	K50 The corrective action for the alleged deficient practice was accomplished by: The Staff member interviewed during the survey was in-serviced on the fire drill procedure. All staff were in-serviced on the fire drill procedures. New Hires upon orientation will be oriented on the facility's fire drill procedure. Random audits will be completed on staff members and the ability to follow proper fire drill procedure. These audits will be conducted weekly X1 month, monthly X 3months and then on an ongoing as needed basis as scheduled. The corrective actions will be monitored through the facility quality assessment performance improvement committee X 3 months. Audits will be reported and the data will be reviewed for patterns or trends. During evaluation recommendations will be made of action plans based upon findings.	12/13/13 12/13/13 12/13/13
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation and staff interview on 10/29/2013 the staff did not know the fire drill procedures. 42 CFR 483.70 (a)	K 050		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

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CONSTRUCTION SE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penny Brown
TITLE: Administrator
(X6) DATE: 11-21-13

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.

CD

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K 076	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 10/29/2013 there were full and empty 02 cylinders mixed in the 02 storage area. 42 CFR 483.70 (a)	K 076	K076 The corrective action for the alleged deficient practice was accomplished by: The empty oxygen tank which was stored incorrectly during the survey was removed and placed in the empty tank holder. Licensed Nurses and Resident Care Specialist were inserviced on the correct placement of the portable oxygen tanks. New Hires upon orientation will be oriented on the portable oxygen tank storage. Random audits on the portable oxygen tank storage area will be completed. These audits will be conducted weekly X 1 month, monthly X 3 months and then on an ongoing basis as needed. The corrective actions will be monitored through the facility quality assessment performance improvement committee X 3 months. Audits will be reported and the data will be reviewed for patterns or trends. During evaluation recommendations will be made of action plans based upon findings. DISCLAIMER CLAUSE 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 provision of federal and state law.	10/29/13 12/13/13 12/13/13