STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	03/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB RD BREVARD, NC 28712

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to follow physician orders and/or facility policy to address bowel movements for three (3) of ten (10) sampled residents. (Residents #49, #136, #148) The findings are: 1. Resident #148 was admitted to the facility 3/17/11 with diagnoses that included mental retardation, liver failure and generalized weakness. The resident's care was being coordinated with Hospice services. The currrent care plan for Resident #148 included a problem area dated 3/25/11 noting the resident "requires staff assistance and intervention for completion of ADL (activity of daily living) needs. Requires total care utilizing 1 staff member." One of the approaches to this problem area was, "Coordinate care with Hospice." The nursing admission assessment completed 3/17/11 indicated Resident #148 had hypoactive bowel sounds, a firm abdomen and that, "patient abdomen is edematous. Per report, no BM (bowel movement) since 3/14/11." A physician's	F 309	F309-D 4/27/11 1. The alleged deficient practice identifying 3 residents with no bowel movements in excess of 3 days was corrected as follows: Resident #148 – The Charge Nurse, obtained and implemented prn order of "Lactolose 15 ml may have every 4 hours as needed (prn) if no bowel movement over 3 days" on resident's MAR on 3/30/2011. The Interdisciplinary Team reviewed and updated care plan on 3/31/2011. Resident #136 – The Director of Nursing obtained Bowel Movement Report, which revealed that resident, had regular bowel movements on 3/28, 3/30, 3/31, 4/1, 4/2, 4/3, 4/6 and 4/8/2011. The Charge Nurse monitored daily and on 4/8/11 prn order for Milk of Mag was received and administered and care plan updated by MDS Coordinator. Resident #49 – The Director of Nursing clarified the order with physician for Dulcolax 10mg q3day if no bowel movement and was transcribed to resident's MAR 3/31/11. 2. Facility residents have the potential to be affected by the same alleged deficient practice. The Director of Nursing reviewed bowel movement report 3/31/2011 to identify additional resident's with no bowel movements in 3 days with none noted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Donna Adams, Administrator | TITLE: ✓ Administrator | (X6) DATE: ✓ 4-22-11

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.

APPROVED
APR 25 2011
BY: DPH

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F 309	Continued From page 1 order was written on 3/17/11 for one dose of a Dulcolax suppository. The resident's March Medication Administration Record (MAR) reflected the Dulcolax suppository was administered 3/17/11. A Hospice admission note dated 3/18/11 indicated, "The patient's last stool was March 14, 2011 and stool pattern is one stool per day." "Concerned about patient's bowels. Ordered Lactulose 15 ml PO daily for constipation." On 3/18/11 an order was written for, "Lactulose 15 ml orally every AM for constipation. May have every four hours as needed (PRN) if no bowel movement over three days." Review of the March MAR for Resident #148 revealed the daily dose of 15 ml of Lactulose but the additional PRN dose was not recorded on the MAR. Review of facility bowel records for Resident #148 revealed the following time frames recorded between bowel movements: 3/18/11 First shift-medium bowel movement 3/23/11 Third shift-small bowel movement This reflected a five day period without a bowel movement. 3/23/11 Third shift-large bowel movement 3/28/11 Second shift-large bowel movement This reflected a five day period without a bowel movement. Review of nurses notes and the resident's March MAR revealed the two five day time frames without a bowel movement had not been identified or addressed. On 3/31/11 at 10:35 AM Licensed Nurse (LN) #1 reported that she transcribed the 3/181/11 order	F 309	F309-D (cont) 4/27/11 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: The Bowel Movement report will be reviewed daily by Charge Nurse or other designated licensed staff to identify residents with no bowel movements in 9 shifts and will review orders and contact physician for additional orders if necessary and note on 24-hour report. The Charge Nurse will verify with Resident Care Specialists bowel movement results per resident per shift. New admissions will be reviewed following admission by Interdisciplinary Team identifying risk factors including constipation, hydration issues and physician orders. The Director of Nursing and Charge Nurse met with the Hospice head nurse to establish communication guidelines between Hospice and facility staff related to changes in condition on April 18, 2011. As a result, any changes will be verbally communicated during normal business hours and/or written in communication log. The Staff Development Coordinator will in-service licensed nurses regarding the facility standard of providing necessary measures for residents with no bowel movement in 3 days; hospice communication guidelines and, the Federal/State regulations pertaining to this tag by April 27, 2011.	

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F 309	Continued From page 2 for Lactulose on the MAR for Resident #148. After review of the resident's MAR LN #1 stated she inadvertently left the PRN order for Lactulose off the MAR. LN #1 stated she worked Monday-Friday and checked the bowel records every day to determine any residents that had gone greater than three days without a bowel movement. LN #1 stated she was not aware of any extended times Resident #148 had gone without a bowel movement. LN #1 stated Resident #148 is often seen "digging" in his bowels and found with feces on his hands. LN #1 stated Resident #148 had to have a shower on Monday (3/28/11) because his hands were so full of feces. On 3/31/11 at 10:05 AM the Hospice nurse overseeing care of Resident #148 was interviewed by telephone and reported the Lactulose was ordered on 3/18/11 because the resident was having trouble with his bowels. The Hospice nurse stated Resident #148 is seen by a Hospice nurse twice a week and bowels are assessed at every visit. The Hospice nurse stated they look for a resident to have a bowel movement every day, if not every other day. The Hospice nurse stated if a resident goes longer than three days without a bowel movement then the PRN Lactulose should be given. The Hospice nurse stated she was not aware of the five day time frames Resident #148 had gone without a bowel movement or that the PRN Lactulose was not being administered as it had been ordered on 3/18/11. On 3/31/11 at 11:00 AM the interim Director of Nursing stated the PRN dose of Lactulose should have been put on the MAR of Resident #148 and given when he went greater than three days	F 309		

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F 309	Continued From page 3 without a bowel movement. The interim DON stated the facility was in the process of putting the need to check bowel movements on each residents monthly MARs as a means to remind nursing staff to check residents bowel movements on a daily basis. 2. Resident #136 was admitted to the facility on 11/15/10 and readmitted on 3/9/11 with diagnoses that included constipation and chronic respiratory failure. The most recent Minimum Data Set (MDS) dated 2/8/11 specified the resident had no cognitive impairment, was independent with Activities of Daily Living (ADLs) and continent of bowel and bladder Resident #136's care plan was reviewed and revealed the resident's bowel elimination needs were not care planned. Resident #136's bowel elimination records were reviewed and revealed the following: a. Starting 1/2/11 and continuing for five (5) days no bowel movements were documented. b. Starting 1/26/11 and continuing for four (4) days no bowel movements were documented. c. Starting 3/9/11 and continuing for four (4) days no bowel movements were documented. d. Starting 3/23/11 and continuing for five (5) days no bowel movements were documented.	F 309	F309-D (cont) 4/27/11 4. The Director of Nursing will review the data obtained for patterns and trends. All data results will be presented to the QA&A Committee monthly for a period of 3 months. The QA&A committee will evaluate the effectiveness of the plan based on the outcomes identified. Based on outcomes and trends identified QA&A committee will adjust plan as needed. Corrective action will be completed by April 27, 2011. *Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.*	

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F 309	Continued From page 4 A review of nursing notes for Resident #136 for the periods of 1/2/11 through 1/6/11; 1/26/11 through 1/31/11; 3/9/11 through 3/13/11; and 3/23/11 through 3/27/11 revealed no documentation of assessment or treatment for constipation. Residents #136's Physician's orders were reviewed and revealed on 3/9/11 he was readmitted with an order for Senna (laxative) 8.6 milligrams (mg) by mouth twice daily for constipation. Review of the Medication Administration Records (MARs) for January 2011 and March 2011 and the physician orders revealed no additional orders and/or interventions to address the four (4) episodes of constipation. Resident #136 was unable to be interviewed. The interim Director of Nursing (DON) was interviewed on 3/30/11 at 8:50 a.m. The interim DON stated he expected nurses to initiate physician orders for constipation for residents who went (9) shifts without experiencing a bowel movement or to notify the physician to obtain further treatment orders. Licensed nurse (LN) #2 assigned to the care of Resident #136 was interviewed on 3/30/11 at 10:30 a.m. She reported she received a sheet daily of residents who had not experienced a bowel movement in the last nine (9) shifts. She explained that she was expected to administer as needed (PRN) laxatives if the resident had Physician orders for such or she was to notify the physician of the resident's constipation to obtain further orders. She reported that at the start of her shift on 3/28/11 Resident #136 was on the list for not having had a bowel movement in the last	F 309		

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F 309	Continued From page 5 nine (9) shifts. LN #2 stated Resident #136 did not have PRN orders for a laxative and she did not notify the Physician for further orders. She confirmed she assisted the resident to the bathroom that day but was unaware if the resident had a bowel movement. On 3/30/11 at 2:30 p.m. the nurse aide #1 assigned to care for Resident #136 was interviewed. She reported that daily she records residents bowel movements. She confirmed that for Resident #136 she asks daily at the end of her shift if he had had a bowel movement. The nurse aide reported this was because the resident was alert and oriented, continent of bowel and did not require assistance with toileting. 3. Resident #49 was admitted to the facility on 07/08/09 with diagnosis including Parkinson's disease, dementia and muscle atrophy related to disuse. Resident #49 was admitted to Hospice care on 11/10/10. The latest Minimum Data Set (MDS) dated 02/11/11 indicated Resident #49 had severe cognitive impairment and dependence on staff assistance for all care. The MDS specified the resident was incontinent of bowel and bladder. A care plan for bowel elimination dated 12/06/10 stated Resident #49 was at risk for constipation related to decreased mobility and disease process. The care plan goal stated the resident will have adequate bowel elimination with soft, formed stool at least every three (3) to four (4) days through the next review in ninety (90) days. Interventions on the care plan included: encourage fluids, observe for bowel pattern to ensure adequate bowel elimination, notify	F 309		

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F 309	Continued From page 6 physician as indicated, and enter bowel movements into care tracker each shift. A review of the Hospice admission assessment dated 11/10/10 revealed Resident #49 had a history of constipation and use of laxatives. A review of Resident #49's medical record revealed a laxative (Senna 8.6 milligram) tablet was ordered twice a day until 02/17/11. Continued medical record review revealed all medications were discontinued at this time except for Hospice comfort medications which did not include a laxative. Resident #49's bowel elimination records were reviewed and revealed the following: a. Starting 01/24/11 and continuing for thirteen (13) days no bowel movements were documented. b. Starting 02/07/11 and continuing for seven (7) days no bowel movements were documented. c. Starting 03/10/11 and continuing for eight (8) days no bowel movements were documented. A review of nursing notes for Resident #49 revealed no documentation of assessment for constipation until 03/18/11. Continued nursing notes review revealed the resident was assessed by facility staff and Hospice notified of findings. The constipation was addressed with notification to the physician resulting in a one time order for a laxative which was documented as effective. An interview with Licensed Nurse (LN) #2 revealed the Hospice nurse checks bowel status when she visits. LN #2 stated it is not unusual for Resident #49 to have bowel movements no	F 309		

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F 309	Continued From page 7 frequently than every four (4) days. An interview with the Hospice Nurse (HN) on 03/31/11 at 11:15 a.m. revealed Resident #49 had a history of constipation. The HN stated she relied on input from facility staff in regards to frequency of bowel movements. She stated she expected one (1) to two (2) bowel movements per week for Resident #49 due to limited intake of food and fluids. An interview with the interim Director of Nursing (DON) on 03/31/11 at 2:14 p.m. revealed he expected facility staff to follow the Hospice standard of one (1) to two (2) bowel movements a week for Resident #49. He added he expected facility staff to improve communication with Hospice staff. Continued interview with LN #2 (the day nurse for Resident #49 0 on 03/31/11 at 2:28 p.m. revealed the night shift is supposed to print out bowel frequency reports daily. She added it is the day nurse's responsibility to follow up with residents who have not had a bowel movement within the specified time. LN #2 stated in regards to Resident #49, she either missed the number of days without a bowel movement or nights did not do the printout.	F 309	F371E 4/27/11 1. The Corrective Action has been corrected regarding alleged deficient practice in regard to undated and/or expired food from 100-hall nourishment refrigerator. Dietary Manager immediately removed expired and/or undated foods from refrigerator on 3/28/2011. 2. Facility residents have the potential to be affected by the alleged deficient practice. Dietary Manager checked on 3/28/2011 West, South and North wing nourishment room refrigerators and found no other expired and/or undated food.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to store leftover food past the use by date in one of three nourishment refrigerators. The findings are: An initial tour of the facility was made on 3/28/11 at 10:20 a.m. The 100 Hall nourishment refrigerator was observed with the dietary manager. Inside the refrigerator were the following items: 1. One 24 ounce container of cottage cheese, partially consumed and stored ready for use, was labeled with the manufacturer's use by date of 3/11/11. 2. A biscuit and gravy stored in a Styrofoam container was dated 3/10/11. 3. Leftover food wrapped with aluminum foil was dated 3/11/11. 4. A container of mayonnaise based salad stored with no date or indication for use by. On 3/28/11 at 10:35 a.m. the Dietary Manager was interviewed and reported a dietary staff member was assigned to check nourishment refrigerators daily for outdated and expired food items. The Dietary Manager stated the staff member was trained to discard any food item after three days of the date. The Dietary Manager offered no explanation why the food items were not discarded and allowed to be stored ready for use past the use by date.	F 371	F371E (cont) 4/27/11 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: The Dietary Manager and/or other designated dietary staff will monitor the nourishment refrigerators on each unit daily and will dispose of any expired and/or undated foods. The Dietary staff was in serviced by the Dietary Manager on 3/29/2011 regarding facility policy and procedure related to food storage under sanitary conditions; dietary staff members responsibility for monitoring food storage in the nourishment refrigerators and the Federal/State regulations pertaining to this tag. Beginning April 22, 2011 Dietary Manager and/or Administrator will conduct random observation of the nourishment refrigerators twice a week for two weeks; once week for two weeks and once a month for 2 months. 4. The Dietary Manager will review the data obtained for patterns and trends. All data results will be presented to the QA&A Committee monthly for a period of 3 months. The QA&A committee will evaluate the effectiveness of the plan based on the outcomes identified. Based on outcomes and trends identified QA&A committee will adjust plan as needed. Corrective action will be completed by April 27, 2011. *Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.*	

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 431	F 431 D 4/27/11 1. The Corrective Action has been corrected regarding alleged deficient practice in regard to outdated multidose vials of insulin on medication cart. On 3/31/11 the Charge Nurse removed and discarded the two multidose vials that were identified. 2. Diabetic residents receiving insulin have the potential to be affected by the same alleged deficient practice. The Charge Nurse responsible for the five medication carts checked medication carts on 3/31/2011 and found no other out of date medications. 3. Measures put into place to ensure that alleged deficient practice does not reoccur include: Beginning on 3/31/2011 licensed nurses were in serviced by the Staff Development Coordinator and/or designated Charge Nurse regarding the facility policy and procedure for proper storage of meds; dating, checking and disposal of expired medications and the Federal/State regulations pertaining to this tag. In-service material will be incorporated into the licensed nurses orientation. The medication carts will be monitored at random; weekly for 4 weeks and monthly ongoing; by the Director of Nursing, Staff Development Coordinator and/or Unit Manager to ensure that expired meds are disposed of timely.	

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F 431	Continued From page 10 facility failed to discard two multidose vials of Insulin dated opened greater than twenty-eight (28) days on one (1) of five (5) medication carts. The findings are: An observation of the medication cart on the North Hall on 03/31/11 at 2:31 p.m. revealed two (2) partially used vials of multidose Insulins with dates opened of 02/25/11 and 02/26/11. The vials were available for use. The vials contained a label with instructions indicating they were good for twenty-eight (28) days after opening. Licensed Nurse #2 was present during the observation and confirmed the two (2) multidose Insulin vials were out of date and should not be available for use.	F 431	F431D (cont) 4/27/11 4. The Director of Nursing will review the data obtained for patterns and trends. All data results will be presented to the QA&A Committee monthly for a period of 3 months. The QA&A committee will evaluate the effectiveness of the plan based on the outcomes identified. Based on outcomes and trends identified QA&A committee will adjust plan as needed. Corrective action will be completed by April 27, 2011. *Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the Federal and State law.*	