STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F 225 1. Corrective action has been accomplished related to the alleged deficient practice in regards to Resident #12. The 24 hour initial report and 5-working day report was completed by the Director of Nursing (DON) on June _16__, 2011 and submitted to the Health Care Personnel Registry (HCPR), on June 16__, 2011. 2. Current facility residents have the potential to be affected by the alleged deficient practice. Staff Development Coordinator (SDC) and DON began to in service staff on June _16_, 2011, regarding "*Abuse Policy: Types of abuse, when to report, who they report to and investigation procedure.*" Administrator/Director of Nursing (DON)/Assistant Director of Nursing (ADON) reviewed incident accident reports and concern reports through April 2011 to determine any indications/allegations of abuse or incidents/accidents of unknown origin. A 24-hour report and 5 day investigative report will be completed and submitted to the HCPR for issues identified that may not have been reported previously. 3. Measures put into place to ensure that the alleged deficient practice does not recur: Staff development coordinator **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11 7/12/11 7/12/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/8/11

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.

RECEIVED
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BY: NKR

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to submit the 24-Hour Initial Report and 5-Working Day Report to the Health Care Personnel Registry (HCPR) in one (1) of two (2) sampled investigations for injury of unknown origin (Resident #12). The findings are: Resident #12 was admitted on 8/3/09 with diagnoses which included Alzheimer's Disease, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Resident #12's annual Minimum Data Set dated 5/11/11 assessed short and long term memory problems and the extensive assistance of two persons for transfers. Review of a Change of Condition form dated 6/3/11 revealed on-call Nurse Practitioner notification at 10:30 PM by Licensed Nurse (LN) #4 of bruises on Resident #12's chest and left arm. Review of the facility's investigation dated 6/6/11 revealed the Assistant Director of Nursing (ADON) conducted an investigation of the bruising on 6/6/11. The investigation concluded there was no substantiation of abuse or neglect. Review of the Family Nurse Practitioner's (FNP) visit dated 6/9/11 revealed the assessment of "bruising of unknown origin" and the following documentation: "linear bruising across pt's (patient's) upper torso, right breast and lateral the greatest; however noted some completely healed	F 225	(SDC) and DON provided in service education beginning June 16_, 2011 for staff regarding *"Abuse Policy: Types of abuse, when to report, who they report to and investigation procedure."* The Abuse Policy will be reviewed quarterly with current employees, and during orientation for new employees. Administrator/DON/ADON will review Incident/Accident reports and concern reports daily Monday through Friday beginning June _16_, 2011, to determine indications of abuse or injuries/accidents of unknown origin. Administrator and DON will follow up within 24hours of reported allegation of abuse, or injuries of unknown origin. The 24-hour report and 5 day investigative report will be completed by the Administrator and DON within the timeframe and submitted to the appropriate State facility (HCPR) with proof of fax transmittal to accompany the report. Administrator/DON/Social worker will conduct interviews with at least 3 residents per week x 4 weeks then at least 3 residents monthly ongoing regarding care and treatment received. Issues identified will be handled according to the Abuse **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 225	Continued From page 2 bruising both arms in alignment with torso bruise." Interview with the Director of Nursing (DON) on 6/16/11 at 10:55 AM revealed LN #4, currently on vacation, completed an incident report and did not notify her of the incident when it occurred on Friday, 6/3/11. The DON explained it was the facility's policy for licensed nursing staff to call the DON with injuries of unknown origin. The DON explained an investigation should be started immediately and she was responsible for HCPR notification. The DON reported the 6/3/11 incident report, placed in the ADON's facility mailbox on a Friday evening was not read until 6/6/11. The investigation occurred on 6/6/11. The DON reported the 24-Hour Initial Report and the 5- Working Day report were not submitted to the HCPR because the investigation concluded no sign of abuse or neglect.	F 225	Policy and will report in QAA weekly for 4 weeks then monthly. 4. The Administrator and DON will review data obtained during audits, analyzing for patterns/trends and report in QA&A meeting weekly for 4 weeks then monthly thereafter. The QA&A committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes and trends identified.	7/12/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to notify the physician of nasal spray refusal for one (1) of twelve (12) sampled residents (Resident #12). The findings are: Resident #12 was admitted on 8/3/09 with diagnoses including Chronic Obstructive	F 281	F 281 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident refusal of nasal spray for Resident #12. Licensed nurse notified physician on June _16_, 2011, regarding resident refusal of nasal spray. Orders received to discontinue medication. 2. Current residents have the potential to be affected by the same alleged deficiency. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staff Development Nurse (SDC) audited current resident Medication Administration Records (MARs) on July _11_, 2011, to identify medications that are being refused by residents. Licensed nurse notified Physician regarding residents with refusal of medications, orders received and written as necessary on July _11_, 2011. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: DON, ADON, and SDC provided in service education for licensed nurses beginning July _5_, 2011 regarding "Medication pass: Policy and Procedures for administering medications and notification of Physician regarding omitted or refusal of medications." DON, ADON, RN supervisor will review MAR's daily for two weeks then three times a week ongoing to monitor for omitted or refused medications. Physician will be notified	7/12/11

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F 281	Continued From page 3 Pulmonary Disease. Resident #12's annual Minimum Data Set dated 5/11/11 assessed short and long term memory problems with severely impaired decision making skills. Review of physician's orders dated 6/2/11 revealed medications included Fluticasone nasal spray 50 micrograms (for allergic nasal symptoms) two sprays to each nostril daily. Review of the April 2011, May 2011 and June 2011 Medication Administration Records revealed documentation of the Fluticasone administration. There was no documentation of Fluticasone nasal spray refusals. Review of the Fluticasone pharmacy label revealed a dispense date of 2/13/11 of 120 metered sprays (a sixty day supply) with a hand written opened date of 3/1/11. Interview with Licensed Nurse (LN) #1 on 6/14/11 at 4:30 PM revealed Resident #12 could not follow directions consistently and frequently refused the Fluticasone nasal spray. LN #1 explained she thought other nurses notified the physician of the refusals. Observation on 6/15/11 at 8:12 AM revealed LN #2 administered two sprays to Resident #12's left nostril and one spray to the right nostril. Resident #12 refused the second nasal spray. Interview with LN #2 on 6/15/11 at 8:40 AM revealed Resident #12 frequently refused administration of the nasal spray. LN #2 revealed she did not notify the physician of refusals.	F 281	regarding omissions or refusals when identified. 4. Director of Nursing will review and analyze data regarding notification of physician related to omitted or refused medications, identifying trends/patterns and report to Quality Assessment and Assurance Committee (QA&A) weekly for four weeks then monthly. The QA&A Committee will evaluate the effectiveness of the plan based on outcomes identified. The Committee will develop and implement additional interventions for negative trends to ensure continued compliance. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 281	Continued From page 4 Interview with the Family Nurse Practitioner (FNP) on 6/16/11 at 8:30 AM revealed he was not aware of the Fluticasone refusals. Interview with the Director of Nursing (DON) on 6/16/11 at 9:10 AM revealed she was not aware of Resident #12's refusal of the nasal spray. The DON explained the refusals should be documented on the MAR and the physician notified. Interview with the FNP on 6/16/11 at 2:15 PM explained he would evaluate the need for continuance of the nasal spray.	F 281	F 312 1. Corrective action has been accomplished for the alleged deficient practice in regards to assistance with feeding for Resident #8. Resident #8 was assessed by Occupational therapist on June 16, 2011 and documented that Resident #8 needs assistance with feeding during meals. Care plan and nursing assistant assignment sheet were updated on June _30_, 2011 to reflect resident assistance during meals. Seating chart was developed by the Speech therapist (ST) and Food Service director (FSD) on June _15_, 2011 and posted in dining area to designate appropriate seating for Resident #8. Nursing staff in serviced on June _15,2011, regarding Resident #8 feeding needs and seating arrangement in dining area.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure that one (1) of five (5)sampled residents, who were dependent on staff, received needed staff assistance when eating. (Resident #8) The findings are: Resident #8 was admitted to the facility on 11/14/09 and has diagnoses which include chronic debility, prior stroke and joint stiffness and pain. The resident was assessed on her	F 312	2. Current residents have the potential to be affected by the same alleged deficiency. Speech therapist (ST), Food Service director (FSD) and Director of Nursing (DON) reviewed current residents beginning June _30_, 2011, regarding feeding assistance during meals to determine accuracy of documentation on care plan and nursing assistant's assignment sheets as compared to resident needs. Care plans and Nursing assistant assignment sheets were up dated beginning June _30_, 2011, with resident **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 312	Continued From page 5 most recent Minimum Data Set (MDS) of 04/27/11 as having short term and long term memory problems, having moderately impaired cognitive skills for daily decision making and required extensive assistance with one (1) person physical assistance with eating. Review of the resident's plan of care, which was updated on 06/06/11, revealed a "Problem" related to "Weight Loss/Nutritional Risk". An approach within this plan of care directed nursing staff to feed Resident #8 her meals. On 06/14/11 at 5:48 p.m. staff was observed serving Resident #8 her evening meal in the facility's main dining room. After setting up the resident's meal tray staff was observed to offer her a spoon At 5:50 p.m. Resident #8 was observed to use a fork to place a large bite of food into her mouth, but the food was observed to back out the side of her mouth. A staff member wiped the resident's mouth and then left the resident feeding herself. From 5:53 p.m. to 5:57 p.m. Resident #8 was observed attempting to feed herself by placing large spoonfuls of food onto her spoon and bringing it to her mouth. In the process of attempting to feed herself Resident #8 was observed spilling foods onto herself and to have foods spill out from the left side of her mouth. At 5:57 p.m. a resident, who was eating next to Resident #8's at the dining room table, was observed to wipe foods from Resident #8's face. Observations from 5:57 p.m. to 6:02 p.m. revealed Resident #8's table mate continued to offer and provide Resident #8 with multiple bites of foods and to wipe foods from her mouth while she fed Resident #8. At 6:02 p.m. Nursing Assistant (NA) #2 was observed to redirect the resident away from feeding Resident	F 312	feeding assistance needs. ST and FSD developed a seating chart on June _15_, 2011, for residents in dining areas to accommodate positioning and feeding needs and seating chart posted in dining area. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Speech therapist provided in service education for nursing staff beginning June _15_, 2011 regarding: *"Assistance needed for residents during feeding and seating arrangements in dining area."* DON, ADON, FSD and ST will monitor residents during meals three times per week for four weeks then weekly to assure residents receive assistance with meals as determined necessary and residents are seated according to seating arrangement and needs. 4. DON and/or ST will analyze for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 312	Continued From page 6 #8 and staff then began to feed Resident #8. While being fed by NA #2 Resident #8 was observed to accept foods readily and have no difficulty. Interview with NA #2 on 6/14/11 at 6:50 p.m. revealed that Resident #8 does attempt to feed herself, but needs staff oversight and encouragement to ensure that she is feeding herself correctly and not spilling her foods. NA #2 further explained that when Resident #8 eats in the dining room she will usually sit at a different table than the table she was seated at during the evening meal of 06/14/11. NA #1 explained that when Resident #8 is seated at her "regular" table this allows staff watch her closer if she does attempt to feed herself. Interview with therapy staff on 06/15/11 at 9:20 a.m. revealed that staff should feed Resident #8 all of her meals because of the resident's physical and mental limitations and due to her swallowing problems.	F 312	F 332 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #14's Patanol eye drops. Physician was notified on 6/15/11 by licensed nurse, regarding the potential extra drop into the right eye. No new orders were received. In service education was provided for licensed nurse by the Staff Development nurse (SDC) regarding administering eye drops according to physician orders. Physician was notified 6/15/11 by licensed nurse regarding Resident #15 and administration of Advair inhaler and effectiveness of inhaler. Physician discontinued Advair for Resident #15 on July 7, 2011. In service education was provided for the licensed nurse by the SDC regarding procedure for administering inhalers according to physician order. Physician was notified on 6/15/11 by licensed nurse regarding use of Combivent Inhaler for Resident #12. SDC provided in service education for licensed nurse regarding procedure for administering in halers according to physician orders and manufacturers recommendations. On 6/20/11, physician ordered a mask to be used with the aero chamber for Resident #12 to improve effectiveness of medication. On July 7, 2011 the Physician discontinued the Combivent order for Resident #12. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to maintain a medication error rate of less than five percent by not giving medications as ordered by the physician and according to manufacturer	F 332		

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F 332	Continued From page 7 instructions. During observations of four medication passes three errors were detected in a total of fifty opportunities resulting in a 6% medication error rate. (Residents #12, Resident #14 and Resident #15) The findings are: 1. Resident #14 was admitted to the facility on 02/16/10 with diagnoses including eye irritation. During medication pass on 06/14/11 at 4:38 p.m. LN #3 administered Patanol eye drops one drop into the left (L) eye and two drops into the right (R) eye of Resident #14. A medical record review revealed a physician order dated 06/02/11 for Patanol 0.1% one (1) drop to both eyes twice a day. During an interview on 06/14/11 at 4:47 p.m. with LN #3 she stated one eye drop fell onto the left cheek of Resident #14 before she placed the eye drop into her (L) eye and she didn't realize two drops went into the resident's right (R) eye. 2. Resident #15 was admitted to the facility on 05/01/10 with diagnoses including chronic wheezing and shortness of breath. A review of manufacturer's instructions for the use of a Advair Diskus inhaler stated to inhale before inhaling a dose of the Advair Diskus, breathe out as far as is comfortable, holding the Diskus level and away from the mouth. Put the mouthpiece to the lips and breathe in quickly and deeply through the Diskus, not through the nose, remove the Diskus from the mouth, hold the	F 332	2. Residents receiving eye drops and inhalers have the potential to be affected by the same alleged deficiency. SDC provided in service education for licensed nurses regarding: *"Medication Pass; Policy and Procedure for administering eye drops and inhalers."* Director of Nursing (DON), Assistant Director of Nursing (ADON) and SDC completed an audit on July _11_, 2011 of current residents that have orders for eye drops and inhalers. DON, ADON and SDC began Medication observation pass for licensed nurses on July _6_, 2011, to assure medications are administered according to policy, procedure and physician order. Physician will be notified for concerns related to effectiveness of medication. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: SDC began in service education for licensed nurses on July _5_, 2011 regarding: *"Medication Pass; Policy and procedure for administering eye drops and inhalers."* SDC will provide ongoing in service education quarterly and during new hire orientation for licensed nurses, regarding Medication Pass; Policy and Procedure. DON, ADON and SDC will observe three licensed nurses per week for four weeks then two per week ongoing to assure medications are administered according to policy, procedure and **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 332	Continued From page 8 breath for about ten (10) seconds and breathe out slowly. During medication pass on 06/15/11 at 8:51 a.m. LN #3 was observed to place an Advair inhaler to Resident #15's lips. LN #3 told Resident #15 to "suck on the inhaler." Resident #15 was observed to suck on the inhaler and there was no visible inhalation or exhalation of breath while the inhaler was in her mouth. LN #3 removed the inhaler from the resident's lips and swabbed her mouth with a sponge saturated with water. A medical record review revealed a physician order dated 06/02/11 for Advair 100-50 Discus one (1) puff inhalant every twelve hours. During an interview on 06/15/11 at 8:56 a.m. with LN #3 she verified she told Resident #15 to suck on the inhaler and stated she leaned down next to the resident's mouth and heard her suck on it. During an interview with the Family Nurse Practitioner (FNP) on 06/16/11 at 10:45 a.m. he stated a resident should inhale when an inhaler is administered. He further stated if a resident sucks on the inhaler like it's a straw it's not going to work. He explained sucking on it only pulled the medication into the resident's mouth and the medication did not go down into the lungs where it needed to go to be effective. 3. Resident #12 was admitted on 8/3/09 with diagnoses including Chronic Obstructive Pulmonary Disease. Review of physician's orders dated 6/2/11 revealed medications included Combivent Inhaler two puffs four times daily and to use a spacer.	F 332	physician orders. Physician will be notified regarding discrepancies identified. 4. DON and/or SDC will analyze observations for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 332	Continued From page 9 (Combivent is a medication used to prevent shortness of breath and wheezing. When attached to the inhaler, a spacer provides easier medication delivery.) Observation on 6/14/11 at 4:20 PM revealed Licensed Nurse (LN) #1 shook the Combivent Inhaler and asked Resident #12 to exhale. LN #1 administered one puff which Resident #12 inhaled quickly. After three minutes, LN #1 placed the inhaler to Resident #12's mouth, asked her to inhale and administered the second puff. LN #1 did not ask Resident #12 to exhale prior to the second puff dose and did not use the spacer which was available in the medication cart. (Exhalation deeply through the mouth prior to inhalation is the manufacturer's recommendation for full dose benefit.) Interview with LN #1 on 6/14/11 at 4:30 PM revealed she forgot to ask Resident #12 to exhale prior to the second inhalation dose. LN #1 reported no reason for not using the spacer with the Combivent and explained Resident #12 was inconsistent with directions. Interview with the Family Nurse Practitioner on 6/16/11 at 8:30 AM revealed the spacer should be used with every Combivent dose to ensure accurate administration for Resident #12.	F 332		7/12/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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	345345	A. BUILDING _____ B. WING _____	06/16/2011

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F 441	Continued From page 10 (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 observation, record review and staff interview the facility staff failed to prevent contamination of the caps of two eye drop bottles and failed to clean a resident's finger before a	F 441	F 441 1. Corrective action has been accomplished for the alleged deficient practice in regards to the infection control program related to preventing the spread of infection. Staff development nurse (SDC) began in service education for licensed nurses on 6/15/11, related to providing barriers for items taken into resident room during medication pass and policy and procedure related to obtaining blood glucose test. 2. Facility residents have the potential to be affected by the same alleged deficiency. SDC began in service education on 6/15/11 for facility staff on 6/15/11 regarding: *"Infection Control; Preventing the Spread of Infection."* Director of Nursing (DON), Assistant Director of Nursing (ADON) and SDC began medication pass observations on July _6_, 2011, to assure infection control measures, such as barriers for items taken into resident rooms during medication pass were being utilized to prevent the spread of infection and proper cleaning of residents skin prior to finger stick for blood glucose. Discrepancies identified will be corrected when observed. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: SDC began in service education for facility on 6/15/11 regarding: *"Infection Control; Preventing the Spread* **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 441	Continued From page 11 finger stick blood sugar according to facility policy in two (2) of seven (7) residents observed during medication pass. (Resident #14 and Resident #15) The findings are: 1. Resident #14 was admitted to the facility on 02/16/10 with diagnoses of diabetes mellitus. a. A review of a facility document titled "Passing medications" dated 2009 stated in part "it is important to use a barrier, such as a disposable tray or plastic cup, when carrying an inhaler, eye medication, or patch into the resident's room and for storing the medication/container while administration is occurring." During a medication pass observation on 06/14/11 at 4:38 p.m. LN #3 removed the cap from a Patanol eye drop bottle for Resident #14 and placed the cap onto the resident's overbed table. LN #3 administered the eye drops to Resident #14, put the cap with the contaminated side back on the eye drop bottle and put it back into the medication cart. A review of physician orders dated 06/02/11 revealed Patanol 0.1% one (1) drop to both eyes twice daily. During an interview with LN #3 on 06/15/11 at 9:02 a.m. she stated she had not received any specific instructions regarding where to place the caps of eye drops while administering eye drops to residents. She stated she thought she should have put it in a container and should not have placed it directly onto the overbed table.	F 441	*of Infection."* SDC will provide ongoing in service education regarding Infection control practices and preventing the spread of infection quarterly and during new hire orientation. DON, ADON and SDC will observe three licensed nurses per week for four weeks then two per week ongoing during medication pass to assure Infection control practices are utilized to prevent the spread of Infection. Discrepancies identified will be corrected when observed. 4. SDC will analyze observations for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/2/11

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F 441	Continued From page 12 During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated nurses should place the caps of eye drop bottles on a clean towel on the overbed table and the cap should not be placed directly onto the overbed table. During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she explained nurses are required to watch a medication pass video during their orientation and they are provided an instruction sheet regarding the placement of a barrier when carrying eye medications into a resident's room. b. A review of facility procedure titled "Blood Glucose Tests" from Lippincott, Williams and Wilkins 5th edition stated "wipe the puncture site with an alcohol pad, and allow to dry completely." During a medication pass observation on 06/14/11 at 4:41 p.m. LN #3 went into Resident #14's room to perform a finger stick blood sugar. She put on gloves, removed a paper towel from the towel dispenser in the resident's room, wet it with water from the sink and wiped the resident's finger. LN #3 then stuck Resident #14's finger with a lancet and checked her blood sugar. During an interview on 06/14/11 at 4:45 p.m. with LN #3 she confirmed she wiped Resident #14's finger with the wet paper towel. She further stated she was supposed to use an alcohol sponge to clean the resident's finger but she forgot.	F 441	" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	7/12/11

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F 441	Continued From page 13 During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated nursing staff should use alcohol sponges to clean a resident's finger before performing a finger stick and they should not use a wet paper towel. During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she stated nurses are expected to follow facility policy regarding cleaning a resident's finger before doing a finger stick blood sugar. 2. A review of a facility document titled "Passing medications" dated 2009 stated in part "it is important to use a barrier, such as a disposable tray or plastic cup, when carrying an inhaler, eye medication, or patch into the resident's room and for storing the medication/container while administration is occurring." Resident #15 was admitted to the facility on 05/01/10 with diagnoses of a stroke. A review of physician's orders dated 06/02/11 revealed Artificial Tears four (4) drops to both eyes four times per day. During an observation during medication pass on 06/15/11 at 8:49 a.m. LN #3 removed the cap from a Liquid Tears eye drop bottle for Resident #15 and placed the cap down onto the resident's overbed table. LN #3 administered the eye drops, put the cap with the contaminated side back on the eye drop bottle and put it back into the medication cart. During an interview with LN #3 on 06/15/11 at	F 441	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 441	Continued From page 14 9:02 a.m. she stated she had not received any specific instructions regarding where to place the caps of eye drops while administering eye drops to residents. She stated she thought she should have put it in a container and should not have placed it directly onto the overbed table. During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated nurses should place the caps of eye drop bottles on a clean towel on the overbed table and the cap should not be placed directly onto the overbed table. During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she explained nurses are required to watch a medication pass video during their orientation and they are provided an instruction sheet regarding placement of a barrier when carrying eye medications into a resident's room.	F 441	F 514 1. Corrective action has been accomplished for the alleged deficient practice in regards to Advanced directive orders. Social worker discussed Advanced directives with Resident #5 for clarification and appropriate physician orders were obtained and Advanced Directives form completed by Social worker and resident on June _16_, 2011. Monthly Physician orders dated July 2011, for Resident #5 were updated with accurate Advanced Directives. 2. Facility residents have the potential to be affected by the same alleged deficiency. Chart audit completed by Medical Records director and Social Worker (SW) for current residents on July _5_ , 2011, to identify residents with Advanced directives and physician orders to support the resident's wishes. Advanced directive discrepancies identified were clarified, updated and physician orders were obtained as necessary and completed on July _7_ , 2011. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: In service education provided by Social worker (SW) beginning July 07 , 2011, for licensed nursing staff regarding completion of Advanced directive forms and obtaining Physician order to support Advanced directives. Social worker or Licensed nurse will review **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		7/12/11

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F 514	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document do not resuscitate on the physician's orders for one (1) of twelve (12) sampled resident's. (Resident #5). The findings are: Resident #5 was re-admitted to the facility on 04/26/11 with diagnoses of atrial fibrillation, hyperlipidemia and urinary tract infection. Resident #5's re-admission Minimum Data Set (MDS) dated 05/06/11 specified she had short term and long term memory problems and was moderately impaired with cognitive skills for daily decision making. A review of the Department of Health and Human Services Do Not Resuscitate (DNR) form dated 04/26/11 and located in the front of Resident #5's medical record indicated do not resuscitate. There was no expiration date on the DNR form. A review of the Advance Directives/Medical Treatment Decisions Acknowledgment of Receipt form dated 04/26/11 and signed by Resident #5's medical durable power of attorney indicated do not resuscitate. A review of a hand-written physician order signed by Resident #5's physician and dated 04/26/11 stated do not resuscitate. A review of the printed monthly physician's orders for May and June indicated Resident #5 was a full	F 514	advanced directives with new admitted and readmitted residents, obtain a signed Advanced directive form and Physician order to support the resident's wishes. Social worker or licensed nurse will review Advanced directives with resident and or family members quarterly, annually and significant change, update as necessary and obtain Physician order to support resident wishes. Medical records director will audit four charts per week x 4 weeks then ten charts per month to compare advanced directives to the physician orders for accuracy. Licensed nurse will review Advanced directives at the end of each month during order review to assure Advanced directives are accurate on the monthly Physician orders. Discrepancies identified will be reported to SW or licensed nurse to be corrected. 4. Social worker and Medical records director will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/12/11

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F 514	Continued From page 16 code. During an interview with the Family Nurse Practitioner (FNP) on 06/16/11 at 10:45 a.m. he verified Resident #5 was ordered do not resuscitate when she was re-admitted to the facility. During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated she was unaware the Do Not Resuscitate (DNR) form and the Advance Directives/Medical Treatment Decisions Acknowledgment of Receipt form indicated the resident was do not resuscitate but the physician order sheet indicated full code. She verified the discrepancy had been in Resident #5's medical record since she was re-admitted on 04/26/11 and stated it should have been caught during medical record audits and corrected before now.	F 514	" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	7/12/11