#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB				
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) M A. BUII				X3) DATE SURVEY COMPLETED	
			B. WIN		The state of the s	1	С	
345253			B. WIIN			06/1	14/2011	
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE			
BEYSTONE HEALTH & REHABILITATION			- 83	0 BROWNSBERGER CIRCLE LETCHER, NC 28732				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	The state of the s		_	400	The plan of correction constit	tutes		
F 157 SS=D			۲	157	my written allegation of compliance		ā	
00-0	*				for the deficiencies cited. However,			
	A facility must immed consult with the resid	lately inform the resident;			submission of this plan of cor	submission of this plan of correction		
		dent's legal representative			is not an admission that a deficiency			
		y member when there is an resident which results in			exists or that one was cited			
		tential for requiring physician			correctly. This Plan of Correction is			
	intervention; a signific	cant change in the resident's			submitted to meet requirements			
physical, mental, or psychosocial status deterioration in health, mental, or psych status in either life threatening condition					established by the state and			
		reatening conditions or			law.			
*	significantly (i.e., a ne existing form of treatr consequences, or to treatment); or a decis the resident from the §483.12(a).  The facility must also	complications); a need to alter treatment antly (i.e., a need to discontinue an form of treatment due to adverse uences, or to commence a new form of nt); or a decision to transfer or discharge dent from the facility as specified in 2(a).			It is the policy of this facilithe charge nurse and / or phybe notified of any significant at the time that said change (A. On the day the obser	ysician change occurs. vation		
	or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or				occurred with reside			
					documentation of vit	57:		
					was obtained and ne			
	this section.	ed in paragraph (b)(1) of			checks were done pe			
	S. Proposition ( ) and proceedings and according				hospital discharge or			
		rd and periodically update ne number of the resident's			is our policy now that			
		r interested family member.			8.#//	anyone on neuro checks		
					with any significant			
	This REQUIREMENT	Is not met as evidenced			abnormalities of thei			
	by:				signs will be reported			
	Based on interviews the facility failed to no	and medical record review,			nurse on call, the DO			
	_				the resident's physic	ian.		
		CURRUSED DEODESENTATIVE'S SIGNATURE			- TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL V 8 2011

BY:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345253	B. WNG _		C 06/14/20		1930
	OVIDER OR SUPPLIER	TATION		80 BROWN	RESS, CITY, STATE, ZIP CODE ISBERGER CIRCLE ER, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE PRIATE	(X5) COMPLETION DATE
F 157	(5) residents (Resident The findings are:  Resident #1 was adm 09/04/08 with diagnos Obstructive Pulmonar Congestive Heart Fail Minimum Data Set (Mindicated that Resider for daily decision make her needs known.  Review of the facility's Responsibility for Lear Resident #1's responsibility for Lear Resident with a requesting the resident AM.  Review of a nurse's not the facility was informed to motor vehicle accident Review of hospital recognessented to the Eme 12/25/10 at 12:50 PM involved in a motor verecords further revealed discharged that evenling with instructions to chand neurological check.	condition for one (1) of five at #1).  itted to the facility on ses including Congestive by Disease (COPD) and ure (CHF). The latest DS) dated 11/30/10 at #1 was cognitively intact ing and was able to make  if form "Release of the order of the party signed the sible party signed the hospital at the resident had been in a transfer of the sible party signed the hospital at the resident had been in a transfer of the sible party signed the sible party signed the hospital at the resident #1 was and from the ER to the facility eack vital signs every shift the sible party signed the sible party signed the sible party signed the party signed the sible party signed the party signed the party signed the party signed the sible party signed the party signed	F 157	C.	All residents that had ne checks with vital signs do from January through Juwere audited with no abnormal findings noted. All licensed nursing staff have been educated on importance of neuro che and what abnormal vital signs should be reported the resident's physician. review was also done wital CNA's on the correct to obtain vital signs with emphasis on abnormal results and that all vital are communicated to the charge nurse.  The DON will conduct a weekly audit of all daily signs and neuro checks if any are done, for any abnormal issues. This will done times 4 weeks and then monthly times 2.  Results will be document and submitted to the Quant Assurance Committee for	one Ine Ithe ecks Id to A ith way n an signs e vital f ill be	7/12/11
				<u>L</u>	further review and	lad -	
ORM CMS-256	7(02-99) Previous Versions Obse	olete Event ID: YMN811	Fa	acility II	corrective action if need	ea. ion sh	eet Page 2 of 6

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345253	B. WIN	G		1970-0000	C 14/2011	
NAME OF PROVIDER OR SUPPLIER BEYSTONE HEALTH & REHABILITATION			8	REET ADDRESS, CITY, STATE, ZIP CODE 80 BROWNSBERGER CIRCLE FLETCHER, NC 28732				
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F 157	12/25/10 at 7:40 PM trevealed parameters 10:40 AM the nurse d and at 2:40 PM a BP neurological changes  A nurse's note dated revealed Resident #1 and appeared confuse response. The resider 110/40. Documentation-call nurse practition at 9:30 PM of Resider order was received to hospital.  Review of the hospital of 12/28/10 revealed Resident was received to hospital of 12/28/10 from respiral pulmonary fibrosis and contusion/pulmonary of A telephone interview Licensed Nurse (LN) with Resident #1 on 11 to 7:00 PM shift. When should have called the readings of 71/51 and An interview on 6/13/11 Resident #1's physicial LN to use their clinical residents. If a resident number of a blood pre 70s, he would expect	of vital signs recorded from hrough 12/26/10 at 6:40 AM from 100/50 to 132/74. At occumented a BP of 71/51 of 70/49. No other were noted during this time.  12/26/10 at 9:30 PM was pale, difficult to arouse ed with minimal verbal nt's BP was documented as an further revealed the ner was notified on 12/26/10 at #1's condition and an transfer the resident to the discharge summary dated sident #1 was admitted an 12/27/10. She expired on tory failure secondary to dischest wall contusion.  on 6/13/11 at 9:50 AM with #1 revealed she worked 2/26/10 during the 7:00 AM asked, LN #1 stated she physician with the BP 70/49.	F	157				

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 157 Continued From page 3 have been any different had she been sent to the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  BEYSTONE HEALTH & REHABILITATION  STREET ADDRESS, CITY, STATE, ZIP CODE 80 BROWNSBERGER CIRCLE FLETCHER, NC 28732  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 157  Continued From page 3 have been any different had she been sent to the					· ·	С	
BEYSTONE HEALTH & REHABILITATION    80 BROWNSBERGER CIRCLE   FLETCHER, NC 28732			345253	B. WING _		06/1	4/2011
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE  F 157 Continued From page 3 F 157 have been any different had she been sent to the				8	0 BROWNSBERGER CIRCLE		
have been any different had she been sent to the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE		LO BE	COMPLETION		
hospital after the first change in blood pressure. Resident #1 was a Do Not Resuscitate (DNR) and would have required intubation once admitted to the hospital.  On 6/13/11 at 11:10 AM, the Nurse Practitioner (NP) on call for the facility on 12/26/10 indicated she should have been called after the first abnormal BP on 12/28/10 at 10:40 AM. The NP stated she was not notified of Resident #1's change in condition prior to 12/26/10 at 9:30 PM.  An interview with the Director of Nursing (DON) on 6/14/11 at 11:00 AM revealed she would expect a nurse to notify the doctor of a change, concern or abnormality in any section of the neurological assessment.  F309 BS=D 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 interviews and medical record review, the facility failed to assess a significant change in condition for one (1) of five (5) residents (Resident #1). The findings are:	F 309	have been any difference hospital after the first Resident #1 was a Do and would have requited the hospital.  On 6/13/11 at 11:10 A (NP) on call for the farshe should have been abnormal BP on 12/26 stated she was not not change in condition power of the factor of the farshe was not not concern or abnormality on 6/14/11 at 11:00 A expect a nurse to notic concern or abnormality neurological assessmus 483.25 PROVIDE CAHIGHEST WELL BEIT Each resident must reprovide the necessary or maintain the highes mental, and psychosol accordance with the cand plan of care.  This REQUIREMENT by:  Based on interviews at the facility failed to assecondition for one (1) of (Resident #1).	ant had she been sent to the change in blood pressure.  Not Resuscitate (DNR) red intubation once admitted on the change in 12/26/10 indicated in called after the first 13/10 at 10:40 AM. The NP of the change in				

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345253				06/1	14/2011		
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F 309	Obstructive Pulmonar Congestive Heart Fall Minimum Data Set (Mindicated that Resider for daily decision make her needs known.  Review of hospital recognesented to the Eme 12/25/10 at 12:50 PM involved in a motor verecords further reveal discharged that eveniwith instructions to chand neurological checks were continue instructions. Review of 12/25/10 at 7:40 PM to revealed parameters of 10:40 AM the nurse down and at 2:40 PM a BP oneurological changes.  A nurse's noted dated revealed Resident #1 and appeared confuse response. Documenta on-call nurse practition #1's condition and an transfer the resident to	itted to the facility on les including Congestive ly Disease (COPD) and lure (CHF). The latest DS) dated 11/30/10 Int #1 was cognitively intact ling and was able to make  cords indicated Resident #1 longerous Room (ER) on for evaluation after being lincle accident. The hospital led Resident #1 was ling from the ER to the facility leck vital signs every shift lesks for three (3) days.  In Neurological Assessment Resident #1's neurological ld per ER follow up lof vital signs recorded from laterous house of vital signs recorded from laterous house household.	F 36	It is the policy of this fassess a significant charcondition of a resident appropriate action to profer highest well being.  A. On the day the occurred with redocumentation were obtained a checks with vitation done per hospit orders. It is the this facility now on neuro checks a full assessment documentation nurse's notes. A abnormalities were ported to the administrative reand to the phys.  B. All residents that checks with vitation January the were audited witabnormal finding	beservation esident #1, of vital signs were al discharge policy of that anyone also receive the with in the All significant rell be DON or purse on call cian. It had neuro signs done rough June th no		
	Review of the hospital discharge summary dated			abnormal finding	zs noted.	·	

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		345253	D COSC MAN	3. WNG			С	
NAME OF PROVIDER OR SUPPLIER  BEYSTONE HEALTH & REHABILITATION			80	EET ADDRESS, CITY, STATE, ZIP CODE 0 BROWNSBERGER CIRCLE LETCHER, NC 28732		4/2011		
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F 309	12/28/10 revealed Reback to the hospital of 12/28/10 from respiral pulmonary fibrosis and contusion/pulmonary.  A telephone interview Licensed Nurse (LN) with Resident #1 on 1 to 7:00 PM shift. Whe should have called the readings of 71/51 and An additional interview 10:00 AM indicated shift with the should have called the readings of 71/51 and L2/25/10 and further reviewed the follow up LN #1 indicated she with the should have called the reviewed the follow up LN #1 indicated she with the should have called the reviewed the follow up LN #1 indicated she with the should have a diastolic (bottom reading) BP under a diastolic (bottom reading) Brunder a diastolic (bottom reading) Have the should have a be abnormal but did in #1's vital signs. LN #1 provide narrative note 7:00 AM to 7:00 PM signal have a sig	sident #1 was admitted in 12/27/10. She expired on tory failure secondary to d chest wall contusion.  on 6/13/11 at 9:50 AM with #1 revealed she worked 2/26/10 during the 7:00 AM in asked, LN #1 stated she is physician with the BP 70/49.  w with LN #1 on 6/14/11 at the was aware that Resident comobile accident on evealed she had not in instructions from the ER. rould consider a systolic or eighty (80) to be low and iding) BP under sixty (60) to ot recall reviewing Resident acknowledged she did not is on 12/26/10 during the hift. LN #1 confirmed if she dent for any concerns, she	F	309	C. All licensed nursing staff have been educated on acute change of condition and have received a bootoutlining appropriate sign and symptoms of acute changes as noted in the AMDA clinical practice guidelines in the long tercare setting.  D. The DON will conduct a weekly audit of all daily signs and neuro checks if any are done for any abnormal issues. This will done times 4 weeks and then monthly times 2.  Results will be document and submitted to the Quidest Assurance Committee for further review and corrective action if needs	on oklet gns rm vital f II be ted cality r	7/12/11	
	1.5.4							