

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

PRINTED: 09/07/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 08/25/2011 |
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| NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV | STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BLVD BOX 576 WEAVERVILLE, NC 28787 |
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| (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 |
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| F 156 SS=B | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p> | F 156 | <p>"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 conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p> <p>F-156</p> <p>1. Corrective action for the alleged deficient practice for residents #5, 10, and 12 by initiating notification of their non-coverage of benefits along with their rights to appeal. Neither residents nor their responsible parties requested appeals.</p> <p>2. Residents potentially affected by the alleged deficient practice have been identified by conducting an audit of current facility Medicare A recipients to identify any residents that require notification of ending Medicare benefits and will be notified orally and in writing, which will be completed by the Business Office Manger, Social Worker, and the Resident Care Management Director on 9/13/2011. No residents were noted out of compliance.</p> <p>3. The Interdisciplinary Team (IDT) will be re-educated by the Division Director of Collections on 09/13/2011 regarding "notification of rights, rules, services and charges." The Business Office Manager will be responsible for identification and tracking resident benefit notifications via</p> | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Gaither TITLE: Interim Administrator (X6) DATE: 9/22/11

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.

RECEIVED
SEP 22 2011
BY: MLH
original signature date
9-19-11 mh

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| F 156 | Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This | F 156 | use of the Electronic Care Management Board (ECMB), provided by the Resident Care Management Coordinator, along with the IDT, and Nursing Home Administrator. 4. Resident benefit notification and tracking will be reviewed via the ECMB weekly in the morning IDT meeting weekly for a period of 4 weeks, then bi-monthly for a period of 2 months, then as indicated based on the facility needs. The results of the weekly tracking review will be presented by the Buisness office Manager or Nursing Home Administrator, and reviewed in the monthly Quality Assessment and Assurance (QA and A) meeting for a period of 3 months, then as indicated. The QA and A committee will evaluate the effectiveness of the tracking system and make adjustments if negative results are identified. 5. Date of alleged compliance: September 22, 2011 | | |

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| F 156 | <p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to provide a written two day notice for the discontinuation of medicare benefits for three (3) of three (3) sampled residents. (Resident #5, #10, and #12).</p> <p>The findings are:</p> <p>1. Review of Resident # 5's record revealed Medicare services ended on 07/31/11. No copy of the Notice of Medicare Provider Non-Coverage, CMS Form 10123, was available in the record.</p> <p>On 08/24/11 at 8:50 a.m. an interview with the Financial Counselor revealed she had been hired in the financial position in October, 2010, and when she took the position had not been made aware of the appropriate liability notices to</p> | F 156 | | | |

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| F 156 | <p>Continued From page 3 provide to residents and/or responsible parties.</p> <p>On 08/24/11 at 10:00 a.m. an interview with the Administrator revealed appropriate liability notices should have been made available to the resident and/or responsible parties.</p> <p>2. Review of Resident #10's record revealed Medicare services ended on 04/29/11. A blank Notice of Medicare Provider Non-Coverage, CMS Form 10123, was in the record.</p> <p>On 08/24/11 at 8:50 a.m. an interview with the Financial Counselor revealed she had been hired in the financial position in October, 2010 and when she took the position had not been made aware of the appropriate liability notices to provide to residents and/or responsible parties.</p> <p>On 08/24/11 at 10:00 a.m. an interview with the Administrator revealed appropriate liability notices should have been made available to the resident and/or responsible parties.</p> <p>3. Review of Resident #12's record revealed Medicare services ended on 07/14/11. No copy of a Notice of Medicare Provider Non-Coverage, CMS form 10123, was available in the record.</p> <p>On 08/24/11 at 8:50 a.m. an interview with the Financial Counselor revealed she had been hired in the financial position in October, 2010 and when she took the position had not been made aware of the appropriate liability notices to provide to residents and/or responsible parties.</p> <p>On 08/24/11 at 10:00 a.m. an interview with the</p> | F 156 | | |

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| F 156 | Continued From page 4 Administrator revealed appropriate liability notices should have been made available to the resident and/or responsible parties. | F 156 | | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to make available to residents for review a copy of the plan of correction in effect for the most recent recertification survey in two (2) of two (2) posted survey results. The findings are: On 08/23/11 at 3:00 p.m. an observation was made of the survey results publicly posted at two locations: 1.) on the wall in the main lobby of the facility, and 2.) on the wall near the 200 and 400 halls nursing station. A binder at both locations contained copies of the survey citations but did not include the plan of correction in effect for the citations. On 08/24/11 at 3:05 p.m. the Administrator was | F 167 | F-167 1.The alleged deficient practice was not specific to an individual resident. 2.The survey result postings for the facility have been updated to reflect current survey results along with the facility plan of correction for the alleged deficient practices. 3.The Nursing Home Administrator has been identified to place survey results in the survey book, for future survey activity, assuring that the facility plan of correction is also included along with the survey results. 4.The survey book will be provided by the Nursing Home Administrator, and reviewed in monthly Quality Assessment and Assurance (QA and A) meetings following receipt of survey correspondence to assure readily accessible survey results with the corresponding plan of correction. The QA and A committee will evaluate the effectiveness of the plan and make adjustments if negative results are identified. 5.Date of alleged compliance: September 22, 2011 | | |

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| F 167 | Continued From page 5 shown both binders containing the citations but lacking the plan of correction. She stated the facility plan of correction for the citations should have been included and stated she would add the plan of correction. | F 167 | | | |
| F 281 SS=E | 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, staff and physician interviews, and medical record reviews, the facility failed to do neurological checks on a resident with a head injury from a fall for one (1) of four (4) sampled residents (Resident #120); failed to administer medications on time on two (2) of five (5) halls; and failed to administer nutritional supplements as ordered by the physician for two (2) of three (3) residents (Resident #144 and #74). The findings are: 1. Resident #120 was admitted to the facility with diagnoses that included hip fractures, osteoporosis, and dementia among others. The most recent Minimum Data Set (MDS) dated 07/02/11 specified the resident had moderately impaired cognition and required extensive assistance with activities of daily living. The MDS also specified the resident had one fall with injury. Review of Resident #120's medical record revealed a document entitled "Change of | F 281 | F-281 1. Corrective action for the alleged deficient practice for resident #120 was obtained by sending the resident to the Emergency Room for evaluation on 4/28/2011 after the fall, therefore assuring neurological status. 2. Residents with falls involving head injuries have the potential to be affected by the same alleged deficient practice. Falls with potential head injuries have been reviewed by the Director of Nursing, Unit Manager, and Region Clinical Director from August 1, 2011 thru current to identify and address potential neurological deficient. None were identified. 3. Measures put in place to assure the alleged deficient practice does not reoccur include: re-education of the licensed nurses by the Director of Nursing and/or Staff Development Coordinator in regards to: "post fall assessment requirements, to include neurological checks for residents that have sustained a suspected head injury." During the morning meeting Monday thru Friday, accidents and incidents will be audited by the administrative nurse team, including the Director of Nursing, | | |

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| F 281 | <p>Continued From page 6</p> <p>Condition" dated 04/28/11 at 4:35 p.m. that specified the resident fell when she got up unassisted and sustained a three centimeter laceration to the back of her head. The document also specified the family requested the resident be sent to the hospital Emergency Department. The discharge instructions from the Emergency Department specified to monitor for changes in the resident's condition and notify the medical doctor if changes were observed.</p> <p>Further review of the medical record revealed no documented evidence of neurological checks (a brief neurological assessment to monitor for signs and symptoms of a head injury).</p> <p>The licensed nurse who responded to the resident on 04/28/11 was unavailable for an interview.</p> <p>On 08/25/11 at 10:45 a.m. Licensed Nurse (LN) #2 was interviewed and reported she was assigned to care for Resident #120. She stated she was trained to initiate neurochecks when a resident fell and hit her head. She stated that neuro checks should be documented in the resident's medical record on a sheet entitled "Neurological Record."</p> <p>On 08/25/11 at 11:45 a.m. the Director of Nursing (DON) was interviewed and reported she expected licensed nurses to initiate neurological checks every time a resident fell and hit her head. She reviewed Resident #120's medical record and confirmed there was no documented evidence of neurological checks after the resident's fall on 04/28/11. She was unable to offer any explanation why the licensed nurses</p> | F 281 | <p>Staff Development Coordinator, and/or Resident Care Management Coordinator, to assure falls requiring neurological checks, have had such checks initiated.</p> <p>4.Data obtained during audits will be analyzed for patterns/ trends and reporting, by the administrative nurse team, including the Director of Nursing, Staff Development Coordinator, and/or Resident Care Management Coordinator, in the Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance.</p> <p>5.Date of compliance September 22,2011</p> | | |

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| F 281 | <p>Continued From page 7</p> <p>who cared for Resident #120 after her fall on 04/28/11 failed to initiate neurological checks.</p> <p>On 08/25/11 at 1:00 p.m. Resident #120's physician was interviewed and reported she expected neurological checks to be performed on every resident who fell and hit her head. She confirmed Resident #120 should have had neurological checks done after her fall on 04/28/11.</p> <p>2. Resident #128 was admitted to the facility with diagnoses of diabetes, neuropathy, atrial fibrillation (irregular heartbeat), chronic kidney disease, hypertension, and pain, among others. A review of the latest Minimum Data Set (MDS) dated 06/16/11 revealed the resident was cognitively intact and required extensive to total assistance with most activities of daily living.</p> <p>The physician orders and the Medication Administration Record (MAR) for Resident #128 were reviewed. Among the medications ordered to be given at 9:00 a.m. each day were the following:</p> <p>one med for diabetes ordered daily with food (glimeperide) one med for hypertension ordered twice a day (metoprolol) one med, a diuretic, for chronic kidney disease ordered daily (Lasix) one med for pain ordered three times a day (acetaminophen) one med for neuropathy ordered twice a day (Neurontin) one med for anxiety ordered twice a day (clonazepam)</p> | F 281 | <p>F- 281</p> <p>1. Resident #120 has been evaluated for medication administration time adjustment based on resident need and Physician recommendation to assure timely medication administration. Licensed staff has been re-educated regarding the policy regarding medication management particularly with timeliness and dosing.</p> <p>2. Facility residents receiving medications have the potential to be affected by the alleged deficient practice, and have been reviewed for medication administration time adjustments based on resident need and Physician recommendation by the Director of Nursing, Staff Development Coordinator, and/or RN Supervisor. Medication administration times have been adjusted to reflect these time changes on the Medication Administration Record.</p> <p>3. Measures put in place to assure the alleged deficient practice does not reoccur include: re-education of licensed nurses regarding: <i>"the rights of medication administration, to include timely administration."</i> Medication Pass Audits will be completed, by the Director of Nursing, Unit Manager, Staff Development Coordinator, Consultant Pharmacist, and/or Region Clinical Director at random 5 times per week for a period of 4 weeks to identify medication administration issues.</p> <p>4. Data obtained during audits will be analyzed for patterns/ trends and reporting by the administrative nurse team, including the Director of Nursing, Staff Development</p> | | |

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| F 281 | <p>Continued From page 8</p> <p>one med for anxiety ordered three times a day (buspirone) one med for heart irregularity ordered twice a day (digoxin)</p> <p>On 08/24/11 at 11:30 a.m. Licensed Nurse (LN) #2 was observed passing medications to residents on the 100 hall. She was assisted by a second licensed nurse who was a new employee being oriented by LN #2. At that time LN #2 reported she had three more residents to administer medications to, including Resident #128. These were medications scheduled to be administered at 9:00 a.m.</p> <p>On 08/24/11 at 11:41 a.m. LN #2 was interviewed. She stated she had administered meds to one of the three remaining residents and left the orientee LN to finish the other two remaining residents on the 100 hall who also had meds scheduled at 9:00 a.m. She stated that one of the two residents whose meds had not yet been administered included Resident #128. LN #1 stated that it was acceptable to give a med within the hour before or after the time it was ordered. She stated that meds ordered at 9:00 a.m. needed to be given after 8:00 a.m. and before 10:00 a.m. She stated yesterday she also finished up the meds ordered at 9:00 a.m. after 11:00 a.m. but that she had been running a little later than usual because she was orienting a new nurse. However, she stated that she had been administering meds on the 100 hall for the last three weeks and she always ran past 10:00 a.m., typically finishing at 10:30 to 10:45 a.m. She stated this made giving the meds ordered for a repeated dose at noon a problem and she would have to wait until later in the afternoon to give</p> | F 281 | <p>Coordinator, and/or Resident Care Management Coordinator, in the Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance.</p> <p>5.Date of compliance September 22,2011</p> | | |

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| F 281 | <p>Continued From page 9</p> <p>them, and then inform the evening shift nurse that the meds had been staggered. She stated other nurses had problems finishing the morning med pass on the 100 hall on time as well because there were so many meds on that hall. LN #2 stated she had informed the Director of Nursing (DON) that she could not get her meds passed on time on the 100 hall.</p> <p>On 08/24/11 at 12:31 p.m. LN #5 was interviewed. She stated she had been hired two months before and worked the 100 hall Monday through Friday until about three weeks ago when LN #2 replaced her. She also stated that it was acceptable to give a med within the hour before or after the time it was ordered, but that she never finished the morning meds on the 100 hall before 10:00 a.m. She stated she typically could not finish until around 11:00 a.m. every day, an hour past the acceptable parameter. She stated that she could finish her meds within the parameters on the other halls, but that the 100 hall had so many meds that no nurse could finish them on time. She stated that she had discussed this with the Director of Nursing.</p> <p>On 08/24/11 at 1:52 p.m. the DON was interviewed. She stated that she had been made aware that completing the morning medication pass on the 100 hall within the acceptable parameters of one hour before or after the ordered time had been a problem. She stated the problem was not the nurses but the volume of meds on that hall. She stated that her plan was to put an additional LN on the 100 hall to assist with the med pass tomorrow.</p> <p>On 08/25/11 at 11:18 a.m. a follow-up interview</p> | F 281 | | | |

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| F 281 | <p>Continued From page 10</p> <p>was conducted with the DON. She stated that certain categories of meds such as diuretic meds, and meds for hypertension, pain, and anxiety, needed to be given on time to be effective. She added that medication administration could create a problem if given significantly late when the same medications were repeated throughout the day, as doses could be too close together. The DON stated it was her expectation that medications were administered in a timely manner.</p> <p>3. Resident #61 was admitted to the facility with diagnoses of hypertension, and pain, among others. A review of the latest Minimum Data Set (MDS) dated 06/18/11 revealed the resident had short and long term memory problems and moderate impairment in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with most activities of daily living.</p> <p>The physician orders and the Medication Administration Record (MAR) for Resident #61 were reviewed. Among the medications ordered to be given at 9:00 a.m. each day were the following:</p> <p>one med for hypertension, a diuretic, ordered at 9:00 a.m. and 1:00 p.m. (furosemide) one med for hypertension ordered twice a day (metoprolol) one med for electrolyte replacement ordered three times a day (potassium) one med for pain ordered four times a day (Norco)</p> <p>On 08/24/11 at 11:30 a.m. Licensed Nurse (LN)</p> | F 281 | | | |

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| F 281 | <p>Continued From page 11</p> <p>#2 was observed passing medications to residents on the 100 hall. She was assisted by a second licensed nurse who was a new employee being oriented by LN #2. At that time LN #2 reported she had three more residents to administer medications to, including Resident #61. These were medications scheduled to be administered at 9:00 a.m.</p> <p>On 08/24/11 at 11:41 a.m. LN #2 was interviewed. She stated she had administered meds to one of the three remaining residents and left the orientee LN to finish the other two remaining residents on the 100 hall who also had meds scheduled at 9:00 a.m. She stated that one of the two residents whose meds had not yet been administered included Resident #61. LN #1 stated that it was acceptable to give a med within the hour before or after the time it was ordered. She stated that meds ordered at 9:00 a.m. needed to be given after 8:00 a.m. and before 10:00 a.m. She stated yesterday she also finished up the meds ordered at 9:00 a.m. after 11:00 a.m. but that she had been running a little later than usual because she was orienting a new nurse. However, she stated that she had been administering meds on the 100 hall for the last three weeks and she always ran past 10:00 a.m., typically finishing at 10:30 to 10:45 a.m. She stated this made giving the meds ordered for a repeated dose at noon a problem and she would have to wait until later in the afternoon to give them, and then inform the evening shift nurse that the meds had been staggered. She stated other nurses had problems finishing the morning med pass on the 100 hall on time as well because there were so many meds on that hall. LN #2 stated she had informed the Director of Nursing</p> | F 281 | | |

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| F 281 | <p>Continued From page 12</p> <p>(DON) that she could not get her meds passed on time on the 100 hall.</p> <p>On 08/24/11 at 12:31 p.m. LN #5 was interviewed. She stated she had been hired two months before and worked the 100 hall Monday through Friday until about three weeks ago when LN #2 replaced her. She also stated that it was acceptable to give a med within the hour before or after the time it was ordered, but that she never finished the morning meds on the 100 hall before 10:00 a.m. She stated she typically could not finish until around 11:00 a.m. every day, an hour past the acceptable parameter. She stated that she could finish her meds within the parameters on the other halls, but that the 100 hall had so many meds that no nurse could finish them on time. She stated that she had discussed this with the Director of Nursing.</p> <p>On 08/24/11 at 1:52 p.m. the DON was interviewed. She stated that she had been made aware that completing the morning medication pass on the 100 hall within the acceptable parameters of one hour before or after the ordered time had been a problem. She stated the problem was not the nurses but the volume of meds on that hall. She stated that her plan was to put an additional LN on the 100 hall to assist with the med pass tomorrow.</p> <p>On 08/25/11 at 11:18 a.m. a follow-up interview was conducted with the DON. She stated that certain categories of meds such as diuretic meds, and meds for hypertension and pain, needed to be given on time to be effective. She added that medication administration could create a problem if given significantly late when the same</p> | F 281 | | | |

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| F 281 | <p>Continued From page 13</p> <p>medications were repeated throughout the day, as doses could be too close together. The DON stated it was her expectation that medications were administered in a timely manner.</p> <p>4. Resident #112 was admitted to the facility with diagnoses of Alzheimer's Disease, diabetes, and hypertension, among others. A review of the latest Minimum Data Set dated 07/02/11 revealed the resident was cognitively intact and needed supervision to limited assistance with most activities of daily living.</p> <p>The physician orders and the Medication Administration Record (MAR) for Resident #112 were reviewed. Among the medications ordered to be given at 9:00 a.m. each day were the following:</p> <p>one med for diabetes ordered daily with food (glimeperide) two meds for hypertension ordered twice a day (metoprolol and isosorbide) one med for dementia ordered twice a day (Namenda) one med for lipids ordered twice a day (gemfibrozil) one med for dry eyes ordered twice a day (Systane)</p> <p>On 08/24/11 at 11:30 a.m. Licensed Nurse (LN) #2 was observed passing medications to residents on the 100 hall. She was assisted by a second licensed nurse who was a new employee being oriented by LN #2. At that time LN #2 reported she had three more residents to administer medications to, including Resident #112. These were medications scheduled to be</p> | F 281 | | | |

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| F 281 | <p>Continued From page 14 administered at 9:00 a.m.</p> <p>On 08/24/11 at 11:41 a.m. LN #2 was interviewed. She stated she had just finished administering meds to Resident #112 five minutes before. She stated the orientee LN was finishing the other two residents on the 100 hall who also had meds scheduled at 9:00 a.m. LN #1 stated that it was acceptable to give a med within the hour before or after the time it was ordered. She stated that meds ordered at 9:00 a.m. needed to be given after 8:00 a.m. and before 10:00 a.m. She stated yesterday she also finished up the meds ordered at 9:00 a.m. after 11:00 a.m. but that she had been running a little later than usual because she was orienting a new nurse. However, she stated that she had been administering meds on the 100 hall for the last three weeks and she always ran past 10:00 a.m., typically finishing at 10:30 to 10:45 a.m. She stated this made giving the meds ordered for a repeated dose at noon a problem and she would have to wait until later in the afternoon to give them, and then inform the evening shift nurse that the meds had been staggered. She stated other nurses had problems finishing the morning med pass on the 100 hall on time as well because there were so many meds on that hall. LN #2 stated she had informed the Director of Nursing (DON) that she could not get her meds passed on time on the 100 hall.</p> <p>On 08/24/11 at 12:31 p.m. LN #5 was interviewed. She stated she had been hired two months before and worked the 100 hall Monday through Friday until about three weeks ago when LN #2 replaced her. She also stated that it was acceptable to give a med within the hour before</p> | F 281 | | | |

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| F 281 | <p>Continued From page 15</p> <p>or after the time it was ordered, but that she never finished the morning meds on the 100 hall before 10:00 a.m. She stated she typically could not finish until around 11:00 a.m. every day, an hour past the acceptable parameter. She stated that she could finish her meds within the parameters on the other halls, but that the 100 hall had so many meds that no nurse could finish them on time. She stated that she had discussed this with the Director of Nursing.</p> <p>On 08/24/11 at 1:52 p.m. the DON was interviewed. She stated that she had been made aware that completing the morning medication pass on the 100 hall within the acceptable parameters of one hour before or after the ordered time had been a problem. She stated the problem was not the nurses but the volume of meds on that hall. She stated that her plan was to put an additional LN on the 100 hall to assist with the med pass tomorrow.</p> <p>On 08/25/11 at 11:18 a.m. a follow-up interview was conducted with the DON. She stated that certain categories of meds such as meds for diabetes, and hypertension, needed to be given on time to be effective. She added that medication administration could create a problem if given significantly late when the same medications were repeated throughout the day, as doses could be too close together. The DON stated it was her expectation that medications were administered in a timely manner.</p> <p>5. Resident # 74 was admitted to the facility with diagnoses including vascular dementia, behavior disorder, and anxiety. A Minimum Data Set</p> | F 281 | | |

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| F 281 | <p>Continued From page 16</p> <p>(MDS) dated 06/02/11 indicated impairment of memory and cognition and dependence on staff for all care.</p> <p>A review of Resident #74's Medication Administration Record dated 08/2011 revealed medications ordered at 8:00 a.m. included one (1) potassium supplement and five (5) medications related to behavior/anxiety disorders. The potassium supplement was ordered at 8:00 a.m., noon, and 4:00 p.m. One medication for anxiety was ordered give with food at 8:00 a.m. Another medication for anxiety was ordered at 8:00 a.m. with repeated doses at noon, 4:00 p.m. and 8:00 p.m. Two medications related to behavior modification were ordered twice a day at 8:00 a.m. and 8:00 p.m.</p> <p>On 08/24/11 Licensed Nurse (LN) #4 was observed administering Resident #74's 8:00 a.m. medications at 10:21 a.m. The resident did not receive a substantial snack or meal at the observed time.</p> <p>An interview with Licensed Nurse (LN) #4 on 08/24/11 at 10:26 a.m. revealed she had worked at the facility for four weeks. She stated she was oriented to medication administration on Resident #74's hall once during those four weeks. LN #4 added she was aware she was two hours late administering medications to Resident #74.</p> <p>An interview with the Director of Nursing (DON) on 08/25/11 at 11:18 a.m. revealed medications relating to anxiety and behavior disorders should be administered on time. She added medication administration could create a problem if given significantly late when the same medications</p> | F 281 | | | |

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| F 281 | <p>Continued From page 17</p> <p>were repeated throughout the day, as doses could be too close together. The DON continued it was her expectation medications were administered in a timely manner.</p> <p>6. Resident #144 was admitted to the facility with diagnoses including esophageal reflux and senile dementia. The latest Minimum Data Set (MDS) indicated impairment of memory and cognition and dependence on staff for all care.</p> <p>A review of Resident #144's medical record revealed a physician's order dated 07/21/11 for four ounces of a nutritional supplement to be administered twice a day.</p> <p>An observation on 08/24/11 at 8:56 a.m. revealed Licensed Nurse (LN) #4 prepared one ounce of a nutritional supplement in a one ounce medication cup which she administered to Resident #144.</p> <p>An interview with LN #4 on 08/25/11 at 10:26 am revealed she had filled the cup to the one ounce mark which was also four drams. LN #4 was observed looking at the cup she used to measure the nutritional supplement and she stated the line to which she filled the cup was four drams.</p> <p>An interview with the Director of Nurses on 08/24/11 at 1:17 p.m. revealed she expected a licensed nurse to know how to measure correctly and administer nutritional supplements as ordered by the physician.</p> <p>7. Resident #74 was admitted to the facility with diagnoses including vascular dementia and dysphagia. A Minimum Data Set (MDS) dated 06/02/11 indicated impairment of memory and</p> | F 281 | | | |

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| F 281 | Continued From page 18 cognition and dependence on staff for all care. A review of Resident #74's medical record revealed a physician's order dated 06/13/11 for four ounces of a nutritional supplement to be administered twice a day. An observation on 08/24/11 at 10:26 a.m. revealed Licensed Nurse (LN) #4 prepared one ounce of a nutritional supplement to administer to Resident #74. An interview with LN #4 at that time revealed she had filled the cup to the one ounce mark which was also four drams. LN #4 was observed looking at the cup she used to measure the nutritional supplement and she stated the line to which she filled the cup was four drams. LN #4 administered the nutritional supplement to the resident without further adjustment in the amount prepared. An interview with the Director of Nurses on 08/24/11 at 1:17 p.m. revealed she expected a licensed nurse to know how to measure correctly and administer nutritional supplements as ordered by the physician. | F 281 | | | |
| 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 | F 309 | F- 309 1.The physician and the Director of Nursing have achieved corrective action for the alleged deficient practice for residents #78 and 167 thru review of bowel elimination patterns. Physician's orders have been implemented in regards to constipation. 2.All facility residents have potential to be affected by the alleged deficient practice. The Interdisciplinary Team, including the <u>Director of Nursing, Unit Manger, Staff</u> | | |

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| F 309 | <p>Continued From page 19</p> <p>by: Based on staff interviews and record review the facility failed to manage and implement planned measures for adequate bowel elimination patterns for two (2) of ten (10) sampled residents (Resident #78 and #167).</p> <p>The findings are:</p> <p>1. Resident #78 was admitted to the facility with diagnoses including dementia and constipation. The latest Minimum Data Set (MDS) dated 06/16/11 indicated impairment of memory and cognition and dependence on staff for all care. The MDS specified Resident #78 was frequently incontinent of bowel, was on a bowel toileting program, and required extensive assistance for toileting.</p> <p>A review of Resident #78's bowel elimination care plan updated 07/23/11 revealed the resident continued to be at risk for alteration in bowel elimination related to a diagnosis of constipation, dietary changes, medications, and disease process. The care plan goal stated the resident will have adequate bowel elimination with soft, formed stool at least every three (3) days through the next review due 09/25/11. Care plan interventions included observation for bowel pattern to ensure adequate bowel elimination and notification of the physician as indicated.</p> <p>A review of Resident #78's medical record revealed the resident experienced bowel elimination difficulties in February of 2011. A physician progress note dated 06/01/11 specified a daily laxative was initiated due to continuation of constipation. Additional medical record review</p> | F 309 | <p>Development Coordinator and Resident Care Management Coordinator have reviewed the bowel patterns of residents to identify anyone from September 1, 2011 thru current that have been greater than 9 shifts without a bowel movement. Those residents identified to go greater than 9 shifts have been assessed by the Director of Nursing and the Physician for recommendation for appropriate bowel elimination intervention. Care plans have been updated to reflect changes in care related to bowel elimination.</p> <p>3. Measures put in place to assure the alleged deficient practice does not reoccur include: re-education by the Director of Nursing and/or Staff Development Coordinator, of licensed nurses regarding: <i>adequate management and implementation measures for bowel elimination for constipated residents</i>. Bowel elimination audits will be completed daily Monday thru Friday during the morning meeting, by the Director of Nursing, Unit Manager, Staff Development Coordinator, and/or Region Clinical Director for a period of 4 weeks, then weekly for a period of 4 weeks to identify residents that residents going greater than 9 shifts without a bowel movement has received adequate intervention.</p> <p>4. Data obtained during audits will be analyzed for patterns/ trends and reporting by the administrative nurse team, including</p> | | |

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| F 309 | <p>Continued From page 20</p> <p>revealed no further physician orders related to constipation.</p> <p>A review of Resident #78's bowel elimination record revealed no bowel movement documented any shift from 08/02/11 through 08/13/11. A review of Resident #78's medication administration record for the month of August 2011 revealed no medication relating to bowel evacuation was administered other than the routine daily laxative. A review of nursing notes during this period revealed no documentation of assessment for constipation for Resident #78.</p> <p>An interview with Nursing Assistant (NA) #4 on 08/25/11 at 1:08 p.m. revealed she documented the number of bowel movements for each resident for each shift she worked. NA #4 stated she was unaware of a resident's bowel function patterns because she was unable to see what other nursing assistants were documenting. NA #4 added she did not report to the nurse if a resident did not have a bowel movement on the shifts she worked.</p> <p>An interview with Licensed Nurse (LN) #3 on 08/25/11 at 1:14 p.m. revealed she was aware Resident #79 had experienced bowel elimination problems in the past. LN #3 stated she worked weekends and did not receive any reports from management relating to lack of bowel movements. LN #3 added she was unable to access the computer documentation related to bowel movements and was unaware Resident #78 had gone so long without a bowel movement.</p> <p>An interview with the Director of Nursing (DON) on 08/25/11 at 3:28 p.m. revealed a report is run</p> | F 309 | <p>the Director of Nursing, Staff Development Coordinator, and/or Resident Care Management Coordinator, in the Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance.</p> <p>5.Date of compliance September 22,2011</p> | | |

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| F 309 | <p>Continued From page 21</p> <p>daily Monday through Friday indicating the residents who have not had a bowel movement in the past nine shifts or three days. The DON stated this report is given to the licensed nurses. If a resident had medication orders available related to constipation, the medication was to be administered. If no medication order was available, the licensed nurse should notify the physician. The DON continued she was unable to find a report initiated in August to indicate Resident #78 did not have a bowel movement in twelve (12) days. At this time, the DON reviewed Resident #78's medical record and could find no documentation related to assessments for constipation or physician notification. The DON stated she expected Resident #78's physician to be notified after nine shifts or three days of no bowel movements.</p> <p>2. Resident #167 admitted to the facility with diagnoses that included constipation, and Alzheimer's disease, among others. The most recent Minimum Data Set (MDS) dated 07/17/11 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. The MDS also specified the resident was incontinent of bowel and required extensive assistance with toileting.</p> <p>Review of Resident #167's medical record revealed a physician's order dated 05/12/11 that specified the resident was to receive Miralax powder (laxative) seventeen grams by mouth daily as needed for constipation, and a physician's order dated 05/17/11 for Senna (laxative) two tablets daily for constipation.</p> <p>Resident #167's bowel elimination care plan dated</p> | F 309 | | | |

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| F 309 | <p>Continued From page 22</p> <p>05/12/11 specified the resident was at risk for alteration in bowel function related to constipation, decreased mobility, medication influence and disease process. The care plan specified interventions to prevent constipation that included administration of medications as ordered and observation of bowel pattern to ensure adequate elimination.</p> <p>Resident #167's bowel elimination records were reviewed and revealed the following: Starting on 8/16/11 and continuing for sixteen shifts (five days) no bowel movements were documented.</p> <p>A review of nursing notes for Resident #167 for the periods of 08/16/11 through 08/22/11 revealed no documentation of assessment for constipation or implementation of the resident's laxative ordered for constipation.</p> <p>Review of the Medication Administration Record and physician orders revealed no additional orders and/or interventions to address the episode of constipation.</p> <p>An interview with the Director of Nursing (DON) on 08/25/11 at 3:28 p.m. revealed a report is run daily Monday through Friday indicating the residents who have not had a bowel movement in the past nine shifts or three days. The DON stated this report is given to the licensed nurses. If a resident had medication orders available related to constipation, the medication was to be administered. If no medication order was available, the licensed nurse should notify the physician. The DON reviewed Resident #167's medical record and could find no documentation related to assessments for constipation or</p> | F 309 | | |

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| F 309 | Continued From page 23 physician notification. The DON stated she expected Resident #167's physician to be notified after nine shifts or three days of no bowel movements. | F 309 | | | |
| F 323 SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record and facility documentation review, the facility failed to provide supervision during toileting for a resident with a history of falls for one (1) of four (4) sampled residents (Resident #120). The findings are: Resident #120 was admitted to the facility on 10/19/10 with a hip fracture from a fall at home. While in the facility she fell on 03/11/11 when she ambulated unassisted from the bathroom and sustained a second hip fracture. Her other diagnoses included osteoporosis, dementia and hypertension. The most recent Minimum Data Set (MDS) dated 07/02/11 specified the resident had moderately impaired cognition and required extensive assistance with activities of daily living, including bed mobility, transfers, dressing, toilet | F 323 | F-323 1. Corrective action has been achieved for the alleged deficient practice in regards to Resident #120. Resident #120's Physician was notified of the fall on 04/28/11 by the hall nurse and sent to the Emergency Department. Resident returned to the facility on 04/29/11. Family/responsible party notified. Care plan was reviewed and updated as indicated. The Director of Nursing communicated changes to the resident's plan of care to the direct care staff utilizing the Nursing Assistant assignment sheet. 2. Residents who require assistance with Activities of Daily Living (ADL) including toileting have the potential to be affected by the same alleged deficient practice. The Director of Nursing (DON), Staff Development Coordinator (SDC)/RN supervisor conducted an audit on 09/16/2011, to identify residents that require assistance with Activities of Daily Living (ADL) and toileting and up date Nursing Assistant assignment sheet to reflect residents' current care needs, including toileting, as needed. The DON/SDC/RN supervisor will observe three nursing assistants per week for 4 weeks then six nursing assistants per month for 3 months | | |

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| F 323 | <p>Continued From page 24</p> <p>use and personal hygiene. The MDS also specified the resident used a wheelchair for mobility but was not steady moving on and off the toilet. In addition, the MDS specified the resident had one fall with injury since the previous assessment.</p> <p>Resident #120's Care Area Assessment (CAA) dated 04/08/11 for falls specified the resident was at high risk for falls due to a history of falls with hip fracture and a fall on 03/11/11 with a second hip fracture, dementia, osteoporosis, poor balance, and muscle weakness.</p> <p>Resident #120's fall care plan updated 04/08/11 specified she was at risk for falls related to declining mental status, recent fall and fracture, history of falls, balance problem when standing, decreased muscle coordination, osteoporosis and use of psychotropic medication. Approaches listed in the care plan to minimize the risk for injury related to a fall included one person assistance with transfers.</p> <p>Review of Resident #120's medical record revealed a document titled "Change of Condition" dated 04/28/11 at 4:35 p.m. that specified the resident fell in the bathroom when she got up unassisted and sustained a 3 centimeter laceration to the back of her head. The document also specified the post fall interventions included resident was not to be left unattended while in the bathroom.</p> <p>The Emergency Department reports dated 04/28/11 were reviewed and revealed a computed tomography (CT) scan of the head was performed secondary to head injury from a fall</p> | F 323 | <p>during ADL's and during the provision of toileting assistance to assure staff are providing assistance to residents according to nursing assistant assignment sheet. The Interdisciplinary team (IDT) will review incidents/accidents during morning meeting Monday through Friday to identify additional potential residents. Any accidents/incidents occurring over the weekend will be reviewed in the first Morning Meeting of the following week.</p> <p>3. Monitors put into place to ensure alleged deficient practice does not recur include:</p> <p>The DON/SDC/RN supervisor will review the Nursing Admission Assessments for newly admitted residents and the 24 hour reports daily, Monday through Friday, to identify the care needs of newly admitted residents. This should include ADL assistance required, fall risk potential, as well as supervision required for ADL's. Nurses must also monitor for changes in residents' status that may require a change in residents' level of ADL assistance. The weekend supervisor will review the Nursing Admission Assessment for residents admitted during weekend hours and communicate care needs to direct care staff by using the nursing assistant assignment sheet and/or the interim care plan. The DON/SDC/RN supervisor will update nursing assistant assignment sheet as changes are identified. The Staff</p> | | |

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| F 323 | <p>Continued From page 25</p> <p>with a laceration to the back of the head. The CT results showed "subtle scalp defect in the occipital region compatible with the given history of a laceration. No acute intracranial injury." Further review of the Emergency Department report specified the resident received sutures to her head and returned to the facility on 04/29/11 at 2:30 a.m.</p> <p>Observations made of Resident #120 on 08/23/11 at 8:45 a.m. revealed she wore a personal alarm clipped to her wheelchair. She was not observed to try to stand from her wheelchair.</p> <p>The licensed nurse who responded to the resident on 04/28/11 was unavailable for an interview.</p> <p>On 08/24/11 at 12:25 p.m. the Administrator was interviewed and reported a fall investigation was conducted that concluded the nursing assistant assigned to care for Resident #120 left the resident alone in the bathroom when she fell. The Administrator stated that the resident's functional status fluctuated day to day and the best practice was for the nursing assistant not to leave the resident unattended in the bathroom.</p> <p>On 8/24/11 at 1:25 p.m. Nursing Assistant (NA) #1 was interviewed and reported she was assigned to care for Resident #120 on 04/28/11. NA #1 reported she was aware of Resident #120's history of falls and stated the resident wore a personal alarm attached to her wheelchair to alert staff of unassisted transfer attempts. She added that the resident required extensive assistance with transfers. She added that at times the resident would have impulsive</p> | F 323 | <p>Development Coordinator (SDC) provided education beginning 09/12/2011 for nursing staff in regards to "Preventing resident falls: Providing assistance including supervision required to prevent accidents for residents during care and toileting as indicated on Nursing Assistant Assignment Sheet." The facility will incorporate the training into the new hire orientation for nursing staff. The IDT will conduct facility rounds at least daily Monday through Friday for four weeks, to identify additional training needs and to ensure implementation of care plan interventions to minimize the risk for falls.</p> <p>4. The Administrator/DON will review documentation of observations; incidents/accidents as well as IDT round data and identify patterns or trends and report trends in Quality Assessment and Assurance (QAA) committee weekly for a period of 4 weeks then monthly thereafter. The QAA committee will evaluate the effectiveness of the above plan and adjust the plan based on trends identified.</p> <p>5. Date of compliance September 22, 2011</p> | | |

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| F 323 | <p>Continued From page 26</p> <p>tendencies and attempt to stand unassisted. NA #1 also stated that her usual practice was to stand outside the bathroom door to give the resident privacy but close enough to provide immediate assistance if needed.</p> <p>During the interview with NA #1 on 08/24/11 at 1:25 p.m. she stated that on 04/28/11 in the evening she assisted Resident #120 into bathroom and onto the toilet. During this time the NA reported she realized she did not have wash cloths to complete the resident's care. She added she made the decision to leave the resident on the toilet to retrieve wash cloths. NA #1 reported that she gave the resident her call bell and instructed her to not move from the toilet. The NA stated she left the bathroom and walked to the clean linen cart that was stored in the hallway approximately two resident room doors down from Resident #120's bathroom. The NA stated that when she returned she observed the resident in the floor with blood to the back of her head.</p> <p>On 8/25/11 at 10:30 a.m. NA #2 was interviewed and reported this was the first time she had cared for Resident #120. She explained she was unaware of how much assistance the resident required but would ask the licensed nurse before she assisted the resident to the bathroom. She added that she assumed the resident required extensive assistance with transfers and should not be left alone in the bathroom because the resident wore a personal alarm attached to her wheelchair.</p> <p>On 08/25/11 at 10:45 a.m. Licensed Nurse (LN) #1 was interviewed and reported that she had</p> | F 323 | | | |

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| F 323 | Continued From page 27 cared for Resident #120 often. She recalled an incident that occurred after Resident #120 fell on 04/28/11 when she assisted the resident to the bathroom and found the resident unsafe to be left alone in the bathroom. She reported the resident demonstrated impulsive actions and was quick to try to get up from the toilet unassisted. On 08/25/11 at 10:50 a.m. LN #2 was interviewed and reported she was assigned to care for Resident #120. She reported that Resident #120 was not safe to be alone in the bathroom because of poor safety awareness and impulsive tendencies. | F 323 | | |
| F 412 SS=D | 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and medical record review, the facility failed to provide routine dental care for one (1) of one (1) resident (Resident #66). The findings are: | F 412 | F-412 1. Corrective action has been achieved for the alleged deficient practice in regards to Resident #66. A dental consult has been scheduled on October 11, 2011 at 8am. 2. Residents that require dental services have the potential to be affected by the same alleged deficient practice. The Director of Nursing (DON), Staff Development Coordinator (SDC)/RN supervisor have conducted an audit on 09/13/2011, to identify residents that are in need of dental services and dental services have been arranged for the residents that were noted to be in need of these services. Furthermore, the facility has arranged for in-house consulting dental services to be provided by Dr. Charles Delaine, with Mobile Dental Pros, to assist in meeting the dental needs of the residents on a as needed and routine basis. | |

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| F 412 | <p>Continued From page 28</p> <p>Resident #66 was admitted to the facility with a diagnosis of Alzheimer's Disease, among others. The latest Minimum Data Set (MDS) dated 08/02/11 revealed the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also revealed the resident required extensive assistance with activities of daily living including hygiene. A review of the resident's nutritional care plan revised 08/22/11 revealed an intervention for referral to the dentist as needed.</p> <p>On 08/22/11 at 3:03 p.m. Resident #66 was observed sitting in her wheelchair. She was observed to have multiple missing teeth on the bottom on both sides. Her remaining four front teeth on the bottom appeared to be longer than usual due to gums receding and were all chipped with obvious cracking and heavy yellow calculus. One tooth in the front appeared to be broken in half horizontally.</p> <p>A review of the medical record for Resident #66 revealed no documentation of dental consults or referrals or routine periodic dental examinations.</p> <p>On 08/25/11 at 4:15 p.m. the Medical Records Director was interviewed and stated she was unable to find any documentation of dental consults or referrals or routine periodic dental examinations in the complete medical record of Resident #66.</p> <p>On 08/25/11 at 4:30 p.m. the Social Worker was interviewed. She stated that there was no dentist that came into the facility to perform routine dental exams. She stated that any nursing staff</p> | F 412 | <p>3. Monitors put into place to ensure alleged deficient practice does not recur include: the Resident Care Management Coordinator and/or MDS Coordinator will assess dental status of residents during the MDS assessments to include admission, re-admission, significant change, quarterly, and annual assessments to identify those residents in need of dental services. Those residents found to be in need of dental services will be scheduled for dental services. Licensed nurses will also review oral status of residents upon completion of the nursing assessment on a monthly basis. The need for dental services will be communicated to the Social Worker, via an in-house communication form, to schedule an appointment for the resident. The Staff Development Coordinator initiated in service education for the licensed nurses in regards to, "Identifying dental needs and dental abnormalities requiring dental services, and the process of communicating the need for dental consults."</p> <p>4. The Social Worker will track residents in of dental services via use of the in-house communication forms weekly for a period of 4 weeks then monthly thereafter beginning 09/14/2011. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.</p> <p>5. Date of compliance September 22, 2011</p> | |

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| F 412 | Continued From page 29 member could refer a resident to her for dental care if the resident was assessed to have pain or other dental issues. She stated that she would notify the family to see if they wanted the resident to be seen by a dentist, and refer the resident to the facility transport person who would make the appointment with a local dentist and transport the resident to the appointment. The Social Worker stated that she was not aware of any dental referral for Resident #66. On 08/25/11 at 5:00 p.m. the Director of Nursing examined Resident #66's oral cavity and noted missing teeth, chipped and cracked teeth, and a tooth broken horizontally. She stated the resident needed to be seen by a dentist right away and would refer her. She stated that to her knowledge there were no routine periodic dental examinations for residents, and no dentist who came into the facility on a routine basis to examine residents' teeth. On 08/25/11 at 5:13 p.m. the Administrator was interviewed. She stated that routine oral exams were performed by the MDS assessment nurse who determined if there were a need for a resident to be seen by a dentist. She stated that the MDS nurse did not have any dental training, but that residents assessed to have emergent dental problems were sent out to a dentist. The Administrator stated that no dentist came into the facility to perform routine periodic dental examinations. | F 412 | | | |
| F 518 SS=D | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; | F 518 | F-518 1. Corrective action has been accomplished for the alleged deficient practice by providing emergency procedures training to the identified employee. | | |

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| (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 518 | <p>Continued From page 30</p> <p>periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that one (1) of one (1) laundry employee was aware of fire procedures.</p> <p>The findings are:</p> <p>On 08/24/11 at 3:54 p.m. Laundry Aide #1 was interviewed. When asked, she stated she did not know what she should do and how she would notify other staff in case of a fire in the laundry. She stated she did not know where the nearest red fire alarm pull station was located. She stated she did not know where the nearest fire extinguisher was located. At the time of the interview, a class B & C fire extinguisher was observed on the wall of the laundry approximately ten feet away.</p> <p>On 08/24/11 at 4:01 p.m. the Environmental Services Director, who was employed by an outside vendor providing contract housekeeping services for the facility, was interviewed. He stated that Laundry Aide #1 was his employee and had been employed approximately six weeks ago. He stated she did not receive any formal fire safety training from him, and he was not sure what fire safety training she might have received during the facility orientation for new employees. He stated he did tell her that in case of a fire she should shut down all washers and dryers and report to a meeting area for all staff. He stated</p> | F 518 | <p>2. Facility residents have the potential to be affected by the same alleged deficient practice; therefore, the Staff Development Coordinator has completed an audit of current employee training records related to emergency procedures.</p> <p>3. Measures put into place to ensure that the alleged deficient practice does not recur include: in service for facility staff regarding: "emergency procedures, specifically to include fire procedures, fire alarms, and use of fire extinguishers, missing residents, weather-related procedures, and mechanical/chemical failures"; new staff will receive the same in service training during their orientation period; existing staff will be in serviced at least annually by the Staff Development Coordinator, Maintenance Director or Administrator regarding emergency procedures. The Staff Development Coordinator or Human Resources Coordinator will review Training/Tracking logs on a monthly basis to identify employees who have received emergency procedures training. The facility's Safety Team will conduct monthly questionnaires regarding emergency procedures on at least 10% of employees to ensure continued compliance.</p> | |

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

PRINTED: 09/07/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 08/25/2011 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV | | | STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BLVD BOX 676 WEAVERVILLE, NC 28787 | | |
| (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 518 | <p>Continued From page 31</p> <p>he would expect her to know the location of the nearest red fire alarm pull station and fire extinguisher. He stated he had not trained her in the use of the extinguisher, and was not sure if she had received that training during facility orientation.</p> <p>On 08/25/11 at 4:00 p.m. the Administrator was interviewed. She stated that all contracted vendor employees received facility orientation regarding fire safety and should know what to do in case of fire. She stated that Laundry Aide #1 had seen the fire safety video during facility orientation but her signed acknowledgment that she had seen the video could not be located. She stated that Laundry Aide #1 "Clearly needs more help in fire safety training."</p> <p>At this time, the Administrator provided a copy of an undated employee handbook used by the housekeeping vendor to orient their employees. She also provided a signature card, signed by Laundry Aide #1, indicating that she had received this handbook and understood she was expected to read it and comply with it and direct any questions to her supervisor. The handbook included a section on fire safety entitled Fire Procedure and Evacuation Plan. The section stated that it was the vendor's responsibility to provide training on the facility's particular fire procedure and evacuation plan, including location and use of fire extinguishers, location and operation of the fire alarm system, resident evacuation, and notification procedures if the employee was the person who located the fire.</p> <p>On 08/25/11 at 4:15 p.m. a follow-up interview was conducted with the Environmental Services</p> | F 518 | <p>4. The Staff Development Coordinator or Administrator will review data obtained during questionnaires and audits, analyze the data and report patterns/trends to the QA&A committee monthly. The QA&A committee will evaluate the effectiveness of the above plan, and will add additional interventions based on negative outcomes identified to ensure continued compliance.</p> <p>5. Date of compliance: September 22, 2011.</p> | | |

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| F 518 | Continued From page 32 Director. He stated he had given the handbook to Laundry Aide #1 to read and had her sign the compliance card. He stated he did not go over the material in the handbook with the aid and she did not ask him any questions about it. | F 518 | | | |