STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____ OCT 31 2011	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident and interviews the facility failed to provide maintenance services necessary to maintain a clean, orderly, and comfortable interior. Findings include: 1) On 10/04/2011 at 10:43 a.m. a resident interview was conducted with resident # 21 in room 208 (window bed). During the interview it was noted the footboard on the resident ' s bed was hanging down on one side. Further observation of the footboard revealed there were no screws or bolts attaching the footboard to that side to the bed. The resident was unaware of the missing screws/bolts. The resident was not aware of this or the additional finding noted below as a problem and/or environmental issue. Further observations of the footboard were made on 10/05/2011 at 8:40 a.m. and 10/06/2011 at 9:00 a.m. The footboard was observed on both days to be still hanging without screws or bolts on one side of the resident # 21 ' s bed. On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. The facility was found to have a	F 25?	**"Preparation and /or executation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forthin 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."** 1.Corrective action has been accomplished related to the alleged deficient practice in regards to resident # 21 foot board hardware replaced and foot board securely attached on10/07/11. Ceiling repair completed on room 208 on 10/27. Resident room 301 wall along the bed closest to door crack with a gouge was repaired and painted on10/27/11. Resident room 304 wall behind head board repaired and painted on 10/24/11. Bumper installed on headboard to prevent father wall damage. Grab bar in ladies shower securely attached to wall on 10/6/2011. 2. Facility residents have the potential to be effected by the same alleged deficient practice. Staff re-educated on the procedure to report repairs need to resident equipment or building repairs. Maintenance Director and Administrator completed a 100% audit on 10/19 of all resident rooms. Needed corrections were identified prioritized and scheduled.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa S. Wilson R., LNHA		10/28/2011

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

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F 253	Continued From page 1 procedure for detecting and reporting/documenting needed maintenance to the building and resident equipment. Staff at the nurse ' s station stated when they found an issue needing maintenance and or repair they would fill out a maintenance request located in the maintenance request binder located at the nurse ' s station and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request binder was observed at the nurse ' s station. Blank maintenance request slips were observed to be in the binder for staff access and documentation. On 10/06/2011 at 10:10 a.m. an interview with the facility ' s maintenance manager was conducted. The maintenance manager confirmed the maintenance process noted above and stated that when a maintenance request was documented he would receive the maintenance request slip and would keep it on file. The maintenance manager stated he kept the files showing documentation for current, pending, and deferred maintenance as well as completed maintenance. On 10/06/2011 a review of the maintenance requests (slips) was made with the facility ' s maintenance manager. There was no maintenance repair slip for resident # 21 ' s footboard on her bed. The facility ' s maintenance manager acknowledged the facility has no maintenance requests or documentation showing knowledge of need to repair resident # 21's bed (footboard). The facility ' s maintenance manager stated he had no prior knowledge that the resident ' s bed was in need of repair and could not state when the repair would be	F 253	3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: Staff re-educated on the procedure to report issues with resident equipment or repairs needed on the physical plant. Housekeeping department will keep maintenance repair request on the housekeeping cart. Staff are to report repair needs to the Maintenance Director using the repair request form. Department Managers will conduct rounds daily Monday thru Friday, to identify needed repairs and submit repair request Monday thru Friday during the Interdisciplinary Team Meeting. The repair needs will be prioritized and scheduled for completion. 4. The repair request will also be reviewed monthly by the Maintenance Director and Administrator to analyze for trends. Results will be reported to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance 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.	11/04/2011

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F 253	Continued From page 2 conducted. 2) On 10/04/2011 10:43 a.m. a resident interview was conducted with resident # 21. During the interview it was observed that the ceiling above the resident ' s bed had multiple dark brown stains on it from the wall outward several feet and running half the length of the bed. It was also observed that some of the ceiling texturing paint was missing cracked/peeling in other areas. A repair to the resident ' s ceiling was observed to have been made at some time in the past and additional dark brown stain lines had gone into and around the repaired area. The resident had no information as to the dark lines in the ceiling or when the initial repair had been made. Further observations of the resident ' s ceiling were made on 10/05/2011 at 8:40 a.m. and 10/06/2011 at 9:00 a.m. The ceiling was observed on both days to still have the dark brown stain lines and the cracked/peeling texturing paint above resident # 21 ' s bed. On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. Staff at the nurse ' s station stated when they found an issue they would fill out a maintenance request located in the maintenance request binder and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request binder was observed at the nurse ' s station. Blank maintenance request slips were observed to be in the binder for staff access and documentation.	F 253		

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F 253	Continued From page 3 On 10/06/2011 at 10:10 a.m. an interview with the facility ' s maintenance manager was conducted. The maintenance manager confirmed the maintenance process noted above and stated that when a maintenance request was documented he would receive the maintenance request slip and would keep it on file. The maintenance manager stated he kept the files showing documentation for current, pending, and deferred maintenance as well as completed maintenance. On 10/06/2011 a review of the maintenance requests (slips) was made with the facility ' s maintenance manager. There was no maintenance request slip for the ceiling in resident #1 ' s room. The facility ' s maintenance manager acknowledged the facility has no maintenance requests or documentation showing maintenance had been conducted on the ceiling above resident # 21 ' s bed. The facility ' s maintenance manager stated there had been a leak in the roof above the ceiling above resident # 21 ' s bed (could not remember date) and that the roof had been initially repaired however after the initial repair the ceiling had leaked a second time and a second repair to the roof had been made (date unknown). The maintenance manager stated that he had no documentation for the initial or second repairs and had not had a chance to complete a second repair to the ceiling above resident #21 ' s bed. The facility ' s maintenance manager stated he had to scrape off the old ceiling texturing then paint the ceiling with a new coat of texture paint but could not state when it would be done.	F 253		

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F 253	Continued From page 4 3) On 10/05/2011 at 8:45 a.m. observations were made of the women ' s shower room across from the facility ' s nurse ' s station. During the observation the toilet grab bar in the shower room was attached but loose on the wall. The bar could be easily moved ½ - 1 inch up and down indicating it was not a solid attachment to the wall. A further observation was made on 10/06/2011 at 9:40 a.m. The toilet grab bar was observed to still be loosely attached to the wall and could still be easily moved up and down. On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. Staff at the nurse ' s station stated when they found an issue they would fill out a maintenance request located in the maintenance request binder and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request binder was observed at the nurse ' s station. Blank maintenance request slips were observed to be in the binder for staff access and documentation. On 10/06/2011 at 10:10 a.m. an interview with the facility ' s maintenance manager was conducted. The maintenance manager confirmed the maintenance process noted above and stated that when a maintenance request was documented he would receive the maintenance request slip and would keep it on file. The maintenance manager stated he kept the files showing documentation for current, pending, and deferred maintenance as well as completed maintenance.	F 253		

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F 253	Continued From page 5 On 10/06/2011 a review of the maintenance requests (slips) was made with the facility ' s maintenance manager. There was no maintenance request/repair slip for the toilet grab bar located in the women ' s shower room across from the nurse ' s station. The facility ' s maintenance manager acknowledged the facility had no maintenance requests/slips or documentation showing knowledge of or need to repair the toilet grab bar in the women ' s shower room. The facility ' s maintenance manager stated he had no prior knowledge that the toilet grab bar was in need of repair and stated that the toilet area of the shower room would be closed and he would initiate repairs immediately. 4) On 10/05/2011 at 8:47 a.m. an observation was made of resident room 301. During the observation it was noted that the wall running along the bed closest to the door appeared to be cracked with a gouge in the wall and had paint peeling off the area. The area was approximately 4 foot from the floor. A further observation was made on 10/06/2011 at 9:42 a.m. The wall was observed to still have the gouged area where the paint was peeling and appeared to be cracked. On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. The facility was found to have a procedure for detecting and reporting/documenting needed maintenance to the building and resident equipment. Staff at the nurse ' s station stated when they found an issue	F 253		

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F 253	Continued From page 6 needing maintenance and or repair they would fill out a maintenance request located in the maintenance request binder located at the nurse ' s station and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request binder was observed at the nurse ' s station. Blank maintenance request slips were observed to be in the binder for staff access and documentation. On 10/06/2011 at 10:10 a.m. an interview with the facility ' s maintenance manager was conducted. The maintenance manager confirmed the maintenance process noted above and stated that when a maintenance request was documented he would receive the maintenance request slip and would keep it on file. The maintenance manager stated he kept the files showing documentation for current, pending, and deferred maintenance as well as completed maintenance. On 10/06/2011 a review of the maintenance requests (slips) was made with the facility ' s maintenance manager. There was no maintenance request/repair slip for any work needing to be conducted in room 301 in the maintenance manager ' s files. The maintenance manager acknowledged he had no maintenance requests/slips or other documentation showing knowledge of or need to repair the wall behind the door bed in room 301. The maintenance manager could not state when the repair to the wall would be conducted. 5) On 10/05/2011 at 8:50 a.m. an observations was made of resident room 304. During the	F 253		

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F 253	Continued From page 7 observation it was noted that the wall behind the headboard of the door bed had been gouged by the resident ' s headboard being hit against the wall. The back of the headboard had pieces of wall paint on it where it had been hit against the wall. The gouge in the wall appeared to be 5 inches square. A further observation was made on 10/06/2011. The bed was observed against the wall where the gouge in the wall was. There was no device found on the headboard to keep it from hitting the wall causing damage to the wall. On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. The facility was found to have a procedure for detecting and reporting/documenting needed maintenance to the building and resident equipment. Staff at the nurse ' s station stated when they found an issue needing maintenance and or repair they would fill out a maintenance request located in the maintenance request binder located at the nurse ' s station and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request binder was observed at the nurse ' s station. Blank maintenance request slips were observed to be in the binder for staff access and documentation. On 10/06/2011 at 10:10 a.m. an interview with the facility ' s maintenance manager was conducted. The maintenance manager confirmed the maintenance process noted above and stated that when a maintenance request was documented he would receive the maintenance request slip and would keep it on file. The	F 253		

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F 253	Continued From page 8 maintenance manager stated he kept the files showing documentation for current, pending, and deferred maintenance as well as completed maintenance. On 10/06/2011 a review of the maintenance requests (slips) was made with the facility ' s maintenance manager. There was no maintenance request/repair slip for the gouged wall behind the headboard of the door bed in room 304 in the maintenance manager ' s files. The maintenance manager acknowledged he had no maintenance requests/slips or other documentation showing knowledge of or need to repair the wall behind the door bed ' s headboard in room 304. The maintenance manager could not state when the repair to the wall would be conducted.	F 253	**F279** **"Preparation and /or executation 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."** 1. Corrective action has been accomplished related to the alleged deficient practice in regards to resident #40. A care plan for Hemodialysis was developed and validated that all interventions identified on the care plan were in place. Resident # 97 no longer resides at the facility. Corrective action for resident # 26 has been accomplished. A care plan for vision was developed and implemented. 2. Facility residents have the potential to be effected by the same alleged deficient practice. The Interdisciplinary Team (IDT) will review resident's comprehensive assessment to ensure care plans are in place according to areas identified with the completion of the CAAs. Care plans will be developed for each resident to meet the individual's needs that have been identified in the comprehensive assessment.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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F 279	Continued From page 9 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a care plan for dialysis for 1(Resident #40) of 1 sampled residents; failed to develop a care plan for community discharge for 1 (Resident #97) of 1 sampled residents; and failed to develop a care plan for vision for 1 (Resident #26) of 1 sampled residents. 1. Resident #40 was admitted to the facility on 07/27/11 and was readmitted on 09/13/11. Diagnoses included end-stage renal disease (ESRD), hemo-dialysis; hypertension, chronic obstructive pulmonary disease, osteomyelitis, and depression. Review of the admission MDS (Minimum Data Set) assessment, dated 08/05/11, revealed Resident #40 had no short or long term memory problems; was able to make daily decisions; needed extensive assistance for activities of daily living except for eating; was assessed to be incontinent of bowel and bladder; and was on dialysis. Review of the significant change MDS assessment, dated 09/27/11, revealed Resident #40 was on dialysis. Review of the resident's medical record revealed there was no care plan for dialysis. Review of the facility's contract with the agency providing dialysis for Resident #40 revealed a	F 279	3. Systemic Measures put into place to ensure the same alleged deficient practice does not recur include: Interdisciplinary team was re-educated on 10/14/11 by Lori Ausley, Regional Care Management Coordinator regarding the process of using the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The Resident Care Management Director /designee will review 2 resident assessments who are scheduled for a Care Plan Meeting to ensure comprehensive care plans are implemented x4 weeks and 4 residents monthly x2 months. Results of the reviews will be discussed during the Interdisciplinary Team Meeting weekly times 4 weeks. Corrective measures will be implemented as determined by the Interdisciplinary Team. 4. The Resident Care Director and the Administrator will analyze the results of the care plan reviews for trends. Results will be reported to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance 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.	11/04/2011

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F 279	Continued From page 10 requirement for the facility was to have a care plan for dialysis. An interview, on 10/06/11 at 3:32 PM, was conducted with MDS Nurse #1. MDS Nurse #1 reviewed the care plan for Resident #40 and was unable to locate the care plan for dialysis. She indicated she was not sure why the care plan was not there. An interview, on 10/07/11 at 8:30 AM, was conducted with MDS Nurse #2. MDS Nurse #2 relayed she was sure she had completed a care plan for dialysis for Resident #40. She indicated she had reviewed the present record and the records for the resident's admission on 08/13/11 and was not able to locate the care plan for dialysis. An interview, on 10/07/11 at 8:45 AM, was conducted with the Director of Nursing (DON). The DON relayed her expectation was that a care plan should have been in the resident's medical record. 2. Resident #97 was admitted to the facility on 08/10/11. Diagnoses included cerebral vascular accident, left side hemiplegia, hypertension, and coronary artery disease. Review of the admission MDS (Minimum Data Set) assessment, dated 08/18/11, revealed the resident was moderately impaired cognitively and needed extensive assistance for activities of daily living. The MDS section concerning discharge planning was reviewed and indicated the resident want to talk to someone regarding the possibility of returning to the community.	F 279		

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F 279	Continued From page 11 Review of the CAA (Care Area Assessment) summary, dated 08/20/11, revealed the area for the resident being able to return to the community was identified. The narrative of the CAA indicated the family's desire was the resident would be able to return home to the community. The summary also indicated the resident would not be able to return home alone; and, was receiving physical, occupational and speech therapy to help him reach his highest potential in anticipation of this goal. The summary indicated the facility would proceed to care plan. Review of the resident ' s medical record revealed no care plan for the resident to be able to return to the community. An interview, on 10/06/11 at 3:32 PM, was conducted with MDS Nurse #1. She indicated the Social Worker (SW) was the person who would have completed the return to the community care plan. An interview, on 10/06/11 at 4:15 PM, was conducted with the SW and she confirmed she would be the staff member to complete the care plan for the resident to return to the community.. The SW stated the family desired the resident to be able to go home. She indicated she was not sure why the care plan for returning to the community had not been completed. An interview, on 10/07/11 at 8:45 AM, was conducted with the Director of Nursing (DON). The DON relayed her expectation was that the care plan should have been in the resident's medical record.	F 279		

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Resident #26 was admitted to the facility on 05/26/11 and had diagnoses including Diabetes Mellitus and Hypertension.

The most recent Minimum Data Set (MDS) Assessment (Significant Change) dated 09/0211 showed that the resident had impaired vision, could see large print but not regular print in newspapers and books. The MDS showed that the resident had no corrective lenses.

The Care Area Assessment (CAA) dated 09/09/11 read: " Resident reports impaired vision, unable to read news print. Reports that he needs to see eye doctor. In house eye exams scheduled for 10/18/11. Care plan risks associated with impaired vision. "

A review of the resident ' s Care Plan showed no information related to the resident ' s impaired vision.

MDS Nurse #1 stated in an interview on 10/05/11 at 4:45 PM that there was not a Care Plan for vision for Resident #26 and that she must have missed it. The Nurse stated that she would do a care plan for vision.

In an interview with the Administrator and the Director of Nursing, the Administrator stated that the MDS and CAAs were part of the process to identify problems and to make the decision to care plan or not to care plan. The Administrator stated that if the decision was made to care plan a problem then a care plan should have been

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F 279	Continued From page 13 developed.	F 279	**F329** **"Preparation and /or executation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forthin 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 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to administer 2 medications as ordered by the physician, failed to monitor a medication by not drawing lab work as ordered by the physician and failed to monitor behaviors of a resident taking anti-anxiety	F 329	1.Corrective action has been accomplished related to the alleged deficient practice in regards to resident #74, #80 and #82 On 10/6/2011 the physician for resident #74 was notified by phone. Clarification of orders for Multivitamin and Senekot were received. Physician ordered a Basic Metabolic Panel and Magnesium level at this time. Results were obtained, physician notified, and a copy of the results were put into the medical record. No additional physician orders were received as a result of the lab work. Nurse #1 was educated regarding questioning abnormal orders noted on medication administration record and comparing those orders to the original physician order in the medical record. Physician was notified resident # 80's Depakote level was not obtained as ordered 9/28/11. A Depakote level was re-ordered and obtained 10/6/11. Physician was notified of the results on 10/7/2011. No new orders received. The results of the Depakote level were placed in the medical record. Nurse #3 was re-educated regarding order transcription and the process for ordering labs. Resident # 82 behavior monitoring sheet for anti-anxiety therapy was initiated when identified.	

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F 329	Continued From page 14 medications for 3 of 10 sampled residents whose medications were reviewed (Residents #74, 80 and 82). The findings include: Resident #74 was re-admitted to the facility on 08/24/11 and had diagnoses including Dementia, Diabetes Mellitus, Stage IV Kidney Disease and Constipation. 1a. Review of the admission orders dated 08/24/11 revealed an order for MVI (multiple vitamin) 1 tab PO (by mouth) daily. Review of the Medication Administration Record (MAR) for august 2011 revealed that the MVI was given once a day as ordered. On 10/05/11 a review of the September 2011 monthly physician ' s orders revealed an entry dated 08/24/11 that read: " (Multiple Vitamin-Minerals) 1 tablet by mouth (PO) QID (four times a day). " The monthly orders had been signed by the resident ' s physician. The MAR for September and October 2011 showed an entry that read: " (Multiple Vitamin-Minerals) 1 Tablet by mouth (PO) QID. The MAR for September and October 2011 showed that the medication had been given 4 times a day. During an interview with the Director of Nursing (DON) on 10/05/11 at 3:30 PM, the DON was observed to review the resident ' s medical record and stated that on the admission orders the MVI was ordered once a day. The DON stated that on the September monthly physician ' s orders and the September MAR the medication was written as four times a day. The DON stated in an interview on 10/05/11 at	F 329	2. Other residents receiving Medications, lab monitoring and anti-anxiety therapy have the potential to be effected by the same alleged deficient practice. Licensed nurses re-educated on transcription of physician orders, monthly changeover of medication administration records, initiation of behavior monitoring sheets for resident on anti-anxiety medications and the process for ensuring labs are drawn as ordered. On 10/25/11 the consultant pharmacist conducted a comprehensive review of resident's medication orders. Adverse findings were brought to the attention of the Director of Nursing to ensure appropriate interventions were implemented as indicated.	

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F 329	Continued From page 15 4:30 PM that she had spoken with the resident ' s physician and that he changed the order for the MVI to be given once a day and ordered a chemistry panel and a magnesium level. The DON stated that the physician told her that he signed the orders but did not recall what the orders were. The DON stated in an interview on 10/06/11 at 8:45 AM that the physician ' s orders and MAR for August 2011 were handwritten and at the end of the month the orders were entered into the computer by the ward clerk. The DON stated that the ward clerk must have made an error in putting the orders into the computer because she could not find anywhere in the chart that the medications were ordered as printed on the MAR. The DON stated that she had an issue with a ward clerk entering the medication orders and that now a Registered Nurse was in that position. The DON stated that the admitting physician was new to them and that the staff were still getting used to the way he ordered some medications. The DON stated that she had seen MVI ordered twice a day but never four times a day. Nurse #1 stated in an interview on 10/06/11 at 9:00 AM that the resident had some wound issues and that she did not question the order for the MVI but that she had never seen this medication ordered four times a day. The resident ' s Physician stated in an interview on 10/06/11 at 9:03 AM that the MVI should only be given once a day and that the order entry must have been a typo (typographical error). Nurse #3 stated in an interview on 10/06/11 at	F 329	3. Systemic Measures put into place to ensure the same alleged deficient practice does not recur include: New admission/readmission records will be taken to the (IDT) Interdisciplinary Team Meeting, Monday thru Friday for review. The Director of Nursing/designee will validate Physician orders have been entered into the electronic record system accurately. The physician orders for lab monitoring will be reviewed. The Director of Nursing/designee will bring the facility lab book to the IDT meeting. The lab orders will be reviewed for notation in the lab book and validation of a lab requisition completion. Results of labs will also be reviewed during the IDT meeting to ensure the previous lab orders were carried thru with physician notification as ordered. The DON/designee will conduct random audits of physician order transcription, data entry, lab monitoring and initiation of behavior monitoring sheets as indicated for a minimum 10 new or changed physician orders weekly x 4 weeks, then monthly x 3 months. Negative findings will be addressed immediately. Results of the audits will be reviewed weekly times 4 weeks and monthly times 3 months during the Interdisciplinary Team Meeting. Additional interventions will be implemented as determined necessary by the IDT.	

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F 329	Continued From page 16 2:07 PM that she saw the order for the MVI to be given four times a day but that the other nurses were giving it so she assumed that the order was correct. In an interview with the Administrator and the DON on 10/07/11 at 8:15 AM, the DON stated that the procedure was for the administrative nurses to check the physician ' s order sheet against the new MAR and for the night shift nurses to check the old MAR against the new MAR. The Administrator stated that checking the physician ' s orders with the MAR was a comprehensive check and that this was a human error. 1b. Review of the admission orders dated 08/24/11 revealed an order for Senokot S 1 tablet PO (by mouth) twice a day. Review of the Medication Administration Record (MAR) for August 2011 revealed that the medication was given twice a day as ordered. On 10/05/11 a review of the September 2011 monthly physician ' s orders revealed an entry dated 08/24/11 that read: " (Senokot) 1 tablet by mouth (PO) every other week BID/Q (every) 12 hours. " The monthly orders had been signed by the resident ' s physician. The MAR for September and October 2011 showed an entry that read: " (Senokot) 1 tablet by mouth (PO) every other week BID/Q (every) 12 hours. " The MAR for September showed that the medication had been given on the 7th and the 21st of September and the October MAR indicated that the medication was to be given every 2 weeks. During an interview with the Director of Nursing	F 329	4. Results of the audits will be reported to the Quality Assessment and Assurance Committee monthly x 3 months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. The Quality Assessment and Assurance Committee will develop and implement additional interventions as needed to ensure continued compliance.	11/04/2011

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F 329	Continued From page 17 (DON) on 10/05/11 at 3:30 PM, the DON was observed to review the resident ' s medical record and stated that on the admission orders the Senokot was to be given twice a day. The DON stated that on the September monthly physician ' s orders and the September MAR the medication was written to be given twice a day once every two weeks. There were no physician ' s orders to change the medication from twice a day to every other week. The DON stated in an interview on 10/05/11 at 4:30 PM that she had spoken with the resident ' s physician and that he changed the order for the Senokot to be given twice a day. The DON stated that the physician told her that he signed the orders but did not recall what the orders were. The DON stated in an interview on 10/06/11 at 8:45 AM that the physician ' s orders and MAR for August 2011 were handwritten and at the end of the month the orders were entered into the computer by the ward clerk. The DON stated that the ward clerk must have made an error in putting the orders into the computer because she could not find anywhere in the chart that the medications were ordered as printed on the MAR. The DON stated that she had an issue with a ward clerk entering the medication orders and that now a Registered Nurse was in that position. The DON stated that the ordering physician was new to them and they were still getting used to the way he ordered medications. Nurse #1 stated in an interview on 10/06/11 at 9:00 AM that she had not seen Senokot ordered this way but that she did not question the order.	F 329		

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F 329	Continued From page 18 The resident ' s Physician stated in an interview on 10/06/11 at 9:03 AM that Senokot should be given once or twice a day and that the order entry must have been a typo (typographical error). In an interview with the Administrator and the DON on 10/07/11 at 8:15 AM, the DON stated that the procedure was for the administrative nurses to check the physician ' s order sheet against the new MAR and for the night shift nurses to check the old MAR against the new MAR. The Administrator stated that checking the physician ' s orders with the MAR was a comprehensive check and that this was a human error. 2. Resident #80 was admitted to the facility on 10/25/10 and had diagnoses including Multiple Cerebrovascular Accidents (Strokes) and Bi-Polar Disorder. A review of the medical record revealed a Physician ' s Telephone Order dated 09/18/11 for a depakote level to be drawn. The medical record showed that a depakote level dated 09/21/11 was 105 (therapeutic level 50-100). There was a Physician ' s Telephone Order dated 09/22/11 to decrease the resident ' s depakote to 500mg twice a day and to repeat the depakote level in one week. There were no further lab results for a depakote level on the resident ' s medical record. The Staff Development Coordinator (SDC) stated in an interview on 10/06/11 at 2:30 PM that the repeat depakote level was not done and that Nurse #3 wrote the order. Nurse #3 stated in an interview on 10/06/11 at	F 329		

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F 329	Continued From page 19 2:35 PM that she wrote the order in the lab book to be drawn. The SDC stated in an interview on 10/06/11 at 3:45 PM that when the nurse took the order she should have written the order in the lab book and filled out a lab sheet and put in the book before she ever signed off the order. The SDC stated that the order was not written in the lab book and the lab order sheet had not been completed. The SDC stated that the physician had been called and the depakote level would be drawn that day. In an interview with the Administrator and the Director of Nursing (DON) on 10/07/11 at 8:22 AM the DON stated that when the nurse wrote the order she should have filled out a lab sheet and written the lab in the lab book and that the nurse did not follow the procedure. 3. Resident #82 was admitted to the facility on 6/30/11 with diagnoses of motor vehicle accident trauma, acute pain, substance abuse and anxiety. The care plan dated 6/30/11 indicated Resident #82 was at risk for anti-anxiety medication side effects. A care plan approach to this risk was to assess behaviors manifested by the medication and notify the physician for medication reduction. The care plan also indicated behaviors of resisting care and requesting the increase of medications. A record review of the physician orders indicated a medication order for Valium 2 milligrams 3 times daily as needed dated 6/30/11. A record review of the facility behavior monitoring	F 329		

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F 329	Continued From page 20	F 329		

form for anti-anxiety medication was conducted. The months of August 2011 and October 2011 were not found.

A record review of the Medication Administration Record (MAR) was conducted. The MAR indicated Valium was administered to Resident #82 in August 2011 on the following days: 2nd - 11th, 13th -19th, 21st - 26th and the 28th -31st. The month of October 2011 indicated Valium was administered to Resident #82 on the following days: 1st - 3rd and the 5th.

An interview with Nurse #1 on 10/6/11 at 10:30am indicated that Valium was given to Resident #82 this morning. Resident #82 is monitored for anxiety by observing shakiness and being upset. She indicated his behavior monitoring form should be located in the MAR. The October 2011 behavior monitoring form was unable to be located.

An interview with Nurse #2 on 10/7/11 at 8:22am revealed when psychiatric medications are administered, the nurse staff look for signs of drowsiness and any changes in behaviors. These behaviors are documented on a monthly facility behavioral form located in the MAR. They document "0" if there are no behaviors. If there are behaviors, they have to indicate interventions attempted and any changes in behaviors or mood.

An interview with the Director of Nursing on 10/7/11 at 8:33am indicated the facility behavioral monitoring sheets are completed on residents taking anti-anxiety medications. This sheet helps to monitor behaviors. A monthly facility

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F 329	Continued From page 21 behavioral monitoring form should be filled out and completed.	F 329	F-428	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that the consulting pharmacist complete a comprehensive review of a resident ' s medications by failing to identify and report a discrepancy between the physician ' s admitting orders and the medication administration record (MAR) for 1 of 10 sampled residents whose charts were reviewed (Resident #74). The findings include: Resident #74 was re-admitted to the facility on 08/24/11 and had diagnoses including Dementia, Diabetes Mellitus, Stage IV Kidney Disease and Constipation. 1a. Review of the admission orders dated 08/24/11 revealed an order for MVI (multiple vitamin) 1 tab PO (by mouth) daily. Review of the Medication Administration Record (MAR) for	F 428	**"Preparation and /or executation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forthin 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."** 1.Corrective action has been accomplished related to the alleged deficient practice in regards to resident #74.On 10/6/2011 the physician for resident #74 was notified by phone. Clarification of orders for Multivitamin and Senekot were received. Physician ordered a Basic Metabolic Panel and Magnesium level at this time. Results were obtained, physician notified, and a copy of the results were put into the medical record. No additional physician orders were received as a result of the lab work. Nurse #1 was educated regarding questioning abnormal orders noted on medication administration record and comparing those orders to the original physician order located in the medical record. 2. Facility residents have the potential to be effected by the alleged deficient practice have had a 100% chart audit 10/25 to 10/28 by the consultant pharmacist to identify and report discrepancy between physician orders and the Medication Administration Record. Adverse findings were brought to the attention of the Director of Nursing to ensure appropriate interventions were implemented as indicated.	

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F 428	Continued From page 22 August 2011 revealed that the MVI was given once a day as ordered. On 10/05/11 a review of the September 2011 monthly physician ' s orders revealed an entry dated 08/24/11 that read: " (Multiple Vitamin-Minerals) 1 tablet by mouth (PO) QID (four times a day). " The monthly orders had been signed by the resident ' s physician. The MAR for September 2011 showed an entry that read: " (Multiple Vitamin-Minerals) 1 Tablet by mouth (PO) QID. The MAR for September showed that the medication had been given 4 times a day. Record review showed that the consulting pharmacist had reviewed the resident ' s medical record on 09/26/11. There was no information to indicate that there was a discrepancy with the physician ' s medication orders and the medications being administered to the resident. During an interview with the Director of Nursing (DON) on 10/05/11 at 3:30 PM, the DON was observed to review the resident ' s medical record and stated that on the admission orders the MVI was ordered once a day. The DON stated that on the September monthly physician ' s orders and the September MAR the medication was written as four times a day. The DON stated in an interview on 10/05/11 at 4:30 PM that she had spoken with the resident ' s physician and that he changed the order for the MVI to once a day and ordered a chemistry panel and a magnesium level. The DON stated that the physician told her that he signed the orders but did not recall what the orders were.	F 428	3. Systemic Measures put into place to ensure the alleged deficient practice does not recur include: New admission/readmission records will be taken to the (IDT) Interdisciplinary Team Meeting, Monday thru Friday for review. The Director of Nursing/designee will validate Physician orders have been entered into the electronic record system accurately. Re-Education for the pharmacy consultant completed on 10/7/11by Todd King, Pharm.D,CGP. Education reemphasized the importance of checking the current month's Physicians Order Statement (POS) to orders to the medical record and Medication Administration Record. Eric Stratford Division Director, Pharmacy Service will conduct a comprehensive review of the Medication Administration Record currently in use. Audit will be conducted on 11-1-2011. The DON/designee will conduct random audits of physician order transcription, data entry, lab monitoring and initiation of behavior monitoring sheets as indicated for a minimum 10 new or changed physician orders weekly x 4 weeks, then monthly x 3 months. Negative findings will be addressed immediately. Results of the audits will be reviewed weekly times 4 weeks and monthly times 3 months during the Interdisciplinary Team Meeting. Additional interventions will be implemented as determined necessary by the IDT.	

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F 428	Continued From page 23 The DON stated in an interview on 10/06/11 at 8:45 AM that she would have expected the consulting pharmacist to have identified the discrepancy during his monthly review. The resident ' s Physician stated in a telephone interview on 10/06/11 at 9:03 AM that the MVI should only be given once a day and that the order entry must have been a typo (typographical error). The consulting Pharmacist stated in a telephone interview on 10/06/11 at 9:55 AM that he usually reviewed the previous months MAR on the chart but did not review the current MAR unless there was a specific issue that required him to do so. The Pharmacist stated that if he had seen the order for the MVI to be given four times a day he would have questioned the order. In an interview with the Administrator and the Director of Nursing on 10/07/11 at 8:15 AM the Administrator stated that the purpose of the monthly pharmacist review was to look for irregularities and that the pharmacist should have picked up on this from the physician ' s monthly orders. 1b. Review of the admission orders dated 08/24/11 revealed an order for Senokot S 1 tablet PO (by mouth) twice a day. Review of the Medication Administration Record (MAR) for august 2011 revealed that the Senokot was given twice a day as ordered. On 10/05/11 a review of the September 2011 monthly physician ' s orders revealed an entry dated 08/24/11 that read: " (Senokot) 1 tablet by	F 428	4. Results of the audits and the consultant pharmacy recommendations will be reported and reviewed by the Quality Assessment and Assurance Committee monthly x 3 months. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified. The Quality Assessment and Assurance Committee will develop and implement additional interventions as needed to ensure continued compliance.	11/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

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F 428	Continued From page 24 mouth (PO) every other week BID/Q (every) 12 HRS (hours). " The monthly orders had been signed by the resident ' s physician. The MAR for September 2011 showed an entry that read: " (Senokot) 1 tablet by mouth (PO) every other week BID/Q12 HRS. The MAR showed that the Senokot have been given on the 7th and the 21st of the month. Record review showed that the consulting pharmacist had reviewed the resident ' s medical record on 09/26/11. There was no information to indicate that there was a discrepancy with the physician ' s medication orders and the medications being administered to the resident. During an interview with the Director of Nursing (DON) on 10/05/11 at 3:30 PM, the DON was observed to review the resident ' s medical record and stated that on the admission orders the Senokot was ordered twice a day. The DON stated in an interview on 10/05/11 at 4:30 PM that she had spoken with the resident ' s physician and that he changed the order for the Senokot to be given twice a day. The DON stated that the physician told her that he signed the orders but did not recall what the orders were. The DON stated in an interview on 10/06/11 at 8:45 AM that she would have expected the consulting pharmacist to have identified this discrepancy during his monthly review. The resident ' s Physician stated in a telephone interview on 10/06/11 at 9:03 AM that Senokot should be given once or twice a day and that the	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	10/07/2011

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F 428	Continued From page 25 order entry must have been a typo (typographical error). The consulting Pharmacist stated in a telephone interview on 10/06/11 at 9:55 AM that he usually reviewed the previous months MAR on the chart but did not review the current MAR unless there was a specific issue that required him to do so. In an interview with the Administrator and the Director of Nursing on 10/07/11 at 8:15 AM the Administrator stated that the purpose of the monthly pharmacist review was to look for irregularities and that the pharmacist should have picked this up from the physician ' s monthly orders.	F 428		

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

PRINTED: 10/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

(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
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:30 pm onward, the following item were noncompliant, specific findings include: door going to clean linen side of laundry did not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 018	"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 forthin 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." 1.Corrective action has been accomplished related to the alleged deficient practice in regards to the door going to clean linen side of laundry. Door going into the clean side of laundry was repaired on 10/27/2011 at 1:40pm. Door now will latch for a smoke tight seal. 2. All doors in the facility that are requires to latch and be smoke tight have the potential to be effected by the same alleged deficient practice. All doors were checked on 10/30/2011 by the Maintenance director to assure that all doors will close and latch for a smoke tight seal. Any needed repairs were identified prioritized and scheduled. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: the laundry doors will be checked Monday thru Friday by the Maintenance Director and documented. This check will be on-going due to the variations in the humidity changing the fit of the door and the hazardous area being protected. 4. Results of the Monday thru Friday audit will be reported to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance 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.	12/02/2011
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deneen S. Weber RD, LDNA — TITLE — (X6) DATE: 11/11/2011

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.

GW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 056	Continued From page 1 provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:30 pm onward, the following item were noncompliant, specific findings include: sprinkler system is not equipped with high/low switch(riser room). 42 CFR 483.70(a)	K 056	1. Corrective action Will be accomplished on 11/17/2011 related to the alleged deficient practice in regards to the High/Low switch in the riser room on the sprinkler system. Hiller came is on 11/04/2011 assessed and order the part. Installation of the High/Low switch will occur on 11/17/2011. 2. There is only one sprinkler system in the facility, therefore the only area affected. Correction will occur on 11/17/2011 3. Systemic Measures put into place to ensure the same alleged deficient practice does not recur include will include monitoring the pressure gauge and following any recommendations made by Hiller in regard to remaining in compliance. 4. Maintenance Director will monitor pressure gauge and any recommendation made by Hiller and results will be reported to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance 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.	12/02/2011