AMENDED

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

PRINTED: 09/28/2012
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
	345243	A. BUILDING ______ B. WING ______	C 09/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation. Survey event ID # KY6Y11	F 000	F 323 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 86. Licensed nurse assessed Resident #86 on 9/12/12 with no discomfort noted. MD was notified on 9/12/12 with no new orders given. Director of Nursing (DON) provided in service education for licensed nurses beginning 09/12/2012 regarding following orders/precautions related to specialized diets and diet consistency. 2. Current residents have the potential to be affected by the same alleged deficiency. DON, LPN Unit Coordinator and RN Unit Manager conducted an audit on residents that require a specialized diet on September 12, 2012. The identified residents were observed during mealtime by nursing staff to ensure that the identified residents obtained the proper diet. DON/SDC/RN unit Manager provided in service education for nursing staff beginning September 12, 2012 regarding following orders/precautions related to specialized diets and diet consistency. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012
F 323 SS=D	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, interviews, and record review, the facility failed to monitor 1 (one) of 3 (three) sampled residents on a pureed diet who was at risk of swallowing difficulties. (Resident #86) The findings are: Resident #86 was admitted to the facility with diagnoses which included Senile Delusion and Esophageal Reflux. Review of Resident #86's quarterly Minimum Data Set dated 8/14/12 revealed that Resident #86 was cognitively intact for daily decision making. He was assessed as needing supervision/encouragement and cueing of one person with a regular diet. Review of Resident #86's medical record	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Weler, LNHA
TITLE: Administrator
(X6) DATE: 10/12/2012

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.

original signature 10-4-12 nh

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F 323	Continued From page 1 revealed a physician's order dated 9/4/12 for speech therapy to evaluate and treat as indicated. Review of the speech therapist evaluation dated 9/4/12 revealed a referral for swallowing assessment due to decreased alertness and functioning resulting in pocketing of foods. The speech therapist changed Resident #86's diet to puree due to chewing/swallowing difficulties. The evaluation also requested that Resident #86 continue with restorative dining and be monitored by staff. A physician's order dated 9/4/12 also requested Resident #86's diet be changed to puree with thin liquids. Review of Resident #86's care plan last updated on 9/4/12 revealed a need for a pureed diet with thin liquids. Interventions included speech therapy, restorative dining as tolerated, and provision of diet as ordered. Review of a nursing note dated 9/5/12 revealed a physician's order to change the diet to puree with thin liquids for Resident #86. Review of restorative progress notes dated 9/6/12 revealed Resident #86's diet was changed to puree by the speech therapist for a temporary time to see if there was a problem with eating. Observation of Resident #86 during breakfast on 9/12/12 revealed the breakfast tray being delivered and set-up in Resident #86's room at 8:12 AM by Nurse Aide (NA) #1. After setting up the meal tray NA #1 exited the room.	F 323	3. Measures put into place to ensure that the alleged deficient practice does not recur includes: DON/SDC/RN unit Manager provided in service education for nursing staff beginning September 12, 2012 regarding following orders/precautions related to specialized diets and diet consistency. SDC will provide in service education for newly hired nursing staff during new hire orientation. Department managers and licensed nurses will conduct audits during meal times on 2 residents with specialized diets each meal for 4 weeks, then monthly for 2 months. 4. Director of Nursing will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323 Continued From page 2 F 323

Resident #86's breakfast tray card on 9/12/12 at 8:20 AM documented him receiving a pureed diet and indicated restorative as the dining location. Also on the meal tray was a chocolate and caramel candy bar with the wrapper opened.

Interview with Resident #86 on 9/12/12 at 8:20 AM revealed his family members brought him candy bars because he really liked chocolate.

At 9:03 AM on 9/12/12 Nurse #3 entered Resident #86's room to administer medication. Resident #86 asked Nurse #3 to remove the wrapper from the candy bar. Nurse #3 was observed removing the wrapper from candy bar. Nurse #3 requested that Resident #86 take the medication first as to not spoil his breakfast then eat the candy bar. Nurse #3 placed the unwrapped candy bar back on Resident #86's breakfast tray within the Resident's reach. Nurse #3 then administered Resident #86's morning medications and exited the Resident's room.

Observation at 9:12 AM on 9/12/12 revealed Resident #86 began to eat the mini candy bar. The surveyor interrupted the bite immediately and sought permission from Resident #86 to summons Nurse #3 to verify whether or not he was able to eat the candy bar. Resident #86 agreed.

After entering Resident #86's room by surveyor request, Nurse #3 initially stated she was not sure if Resident #86 had any specific diet restrictions. Nurse #3 viewed Resident #86's breakfast tray card and stated Resident #86 was on a pureed diet so she did not think the Resident could have the candy bar. Nurse #3 reported that Resident

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F 323	Continued From page 3 #86 had been eating candy bars for a while and had just changed to a pureed diet the previous week. Nurse #3 stated she needed to check the Resident's medical record to see if the candy bar was still allowed. Nurse #3 exited the room leaving the opened candy bar on Resident #86's breakfast tray within reach. Upon surveyor prompting, Nurse #3 returned and asked Resident #86 if she could take the candy bar with her to go check to see if the candy bar was allowed while Resident #86 was prescribed a pureed diet. Resident #86 agreed and communicated understanding. Nurse #3 stated the candy bar consisted of caramel and chocolate, but did not have nuts so she thought Resident #86 could eat it but she wanted to double check. At 9:18 AM on 9/12/12 Nurse #3 reviewed Resident #86's medical record and stated the resident's diet changed to puree with thin liquids on 9/4/12. She reported that Resident #86 was on a regular diet before the 9/4/12 and that she saw him eating a candy bar on 9/11/12. Nurse #3 stated she wanted to check with the speech therapist to see if Resident #86 could have the candy bar. At 9:25 AM on 9/12/12 Nurse #3 reported that she was notified by the speech therapist that Resident #86 could not have the candy bar. During an interview with the speech therapist on 9/12/12 at 9:26 AM she stated Resident #86 was prescribed a pureed diet due to the resident not safely managing a regular diet. She stated that Reside #86 should receive supervision and	F 323		

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F 323	Continued From page 4 cueing from staff during each meal, including snacks. She reported based on her assessment, eating a whole candy bar would not be appropriate for Resident #86. She stated she educated staff so they could educate Resident #86's family because they often brought food into the facility. The speech therapist stated that if staff saw Resident #86 consuming food that was not consistent with his diet, staff should remove the items. She reported that due to Resident #86 having coughing and swallowing difficulties all foods he consumed needed to be a pureed consistency. At 9:47 AM on 9/12/12 the speech therapist stated she expected staff to notify her if the resident was observed consuming food that was not pureed so that she could reeducate Resident #86 on the safety purposes. Interview with NA #1 on 9/12/12 at 10:20 AM revealed she delivered and set-up Resident #86's breakfast tray in his room because he refused to dine in the restorative dining room that morning. She reported that she told the NA assigned to him so she would know to go and check on him. During an interview with Nurse #3 on 9/12/12 at 10:40 AM she reported that if she saw Resident #86 attempting to or consuming food that was not pureed she would stop him now that she knows he cannot have it. Nurse #3 stated that Resident #86's responsible party had been notified of his diet; however he was not the one bringing in outside food to the resident. She stated she was not aware if Resident #86's responsible party had notified the other family members of Resident #86's new diet order. She reported that she did	F 323		

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F 323	Continued From page 5 not observe Resident #86 in respiratory distress after eating the candy bar on 9/11/12. Interview with Nurse #1, unit manager on 9/12/12 at 11:11 AM revealed that Resident #86 was assessed on 9/11/12 by Nurse #3 and he displayed no signs of distress. She reported that Resident #86 was assessed because he had consumed a candy bar that was outside of his pureed diet. There was no documentation of this assessment provided. Nurse #1 reported that neither Resident #86 nor his responsible party had signed a waiver pertaining to Resident #86 consuming foods outside of his prescribed diet. During an interview with the Director of Nursing (DON) on 9/12/12 at 11:26 AM she stated that Nurse #3 she should have encouraged Resident #86 not to eat the candy bar. She reported that Resident #86 was care planned for non-compliance with his diet. Prior to end of the survey, documentation of Resident #86's non-compliance was not supplied. In an interview with the speech therapist at 11:49am on 9/12/12 she reported she could not say that it would be acceptable for Resident #86 to consume a candy bar due to the current diet order being for pureed consistency. Review of the speech therapy evaluation dated 9/12/12 revealed aspiration precautions. The speech therapist documented that Resident #86's swallowing initiation was delayed and very variable. The evaluation also documented that silent aspiration at bedside could not be ruled out. During an interview with the physician on 9/13/12	F 323		

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F 323	Continued From page 6 at 7:59 AM he stated it would not be a good idea for Resident #86 to consume a candy bar if the prescribed diet was pureed. He reported that he would expect staff to intervene if they saw Resident #86 eating or about to eat a candy bar due to potential concerns with swallowing.	F 323		
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 observation, staff and physician	F 329	F 329 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 6 GDR (gradual drug reduction) of antidepressant medication according to pharmacy recommendations. Licensed nurse notified physician on 9/12/12 regarding pharmacy recommendations for dosage reduction and orders were implemented to coincide with the changes that the physician ordered. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 33 in regards to obtaining labs for medication dosage adjustment. Licensed nurse notified physician regarding pharmacy recommendations for orders to obtain TSH lab on first lab day of the following month. Lab obtained on 10/03/2012 with no new orders. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 86 in regards to GDR (gradual drug reduction) of psychotropic medication according to pharmacy recommendations. Licensed nurse's notified physician on 9/12/12 regarding pharmacy recommendations for medication dosage **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012

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F 329	Continued From page 7	F 329		

interviews, and record review, the facility failed to monitor medications for three (3) of ten (10) sampled residents reviewed for unnecessary medications. Gradual dose reductions of an antidepressant (Resident #6) and an antipsychotic (Resident #86) were not implemented and the level of a thyroid hormone was not monitored (Resident #33).

The findings are:

1. Resident #6 was admitted to the facility on 7/13/11 with diagnoses which included Depression

Review of physician's orders dated 7/13/11 revealed direction to administer Mirtazapine 45 mg. (milligrams) at bedtime. (Mirtazapine is a medication used to treat Depression.)

Review of the physician's monthly orders dated 8/8/12 revealed orders to continue the bedtime administration of Mirtazapine to Resident #6.

Review of Resident #6's clinical record revealed a pharmacist's recommendation dated 8/15/12 for a gradual dose reduction (GDR) of the Mirtazapine. This recommendation was signed by the physician on 9/5/12 with direction for the Mirtazapine to be decreased to 30 mg. at bedtime.

Review of the September 2012 Medication Administration Record (MAR) revealed the Mirtazapine 45 mg. documented as administered at bedtime from 9/5/12 to 9/11/12. Review of the pharmacy label of the Mirtazapine available for administration to Resident #6 revealed directions

Provider's Plan of Correction (F 329):

reduction. New orders were implemented to coincide with the changes.
Director of Nursing (DON) provided in service education for licensed nurses beginning 09/12/2012 regarding the notification and implementation of pharmacy recommendations for dosage reductions and labs.
2. Current residents have the potential to be affected by the same alleged deficiency. DON, LPN unit coordinator and RN unit manager conducted an audit of current facility residents that have had pharmacy recommendations within the last 30 days for GRD (gradual drug reductions) and lab recommendations. Director of Nursing (DON) notified physician regarding recommendations on 9/12/12. New orders received and implemented. Director of Nursing (DON) provided in service education for licensed nurses beginning 09/12/2012 regarding the notification and implementation of pharmacy recommendations for dosage reductions and labs.

3.Measures put into place to ensure that the alleged deficient practice does not recur includes: Pharmacist will provide a consultant recommendation report to the DON each month. The DON will

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F 329	Continued From page 8 to administer 45 mg. at bedtime. Interview with Nurse #1, unit manager, on 9/12/12 at 3:14 PM revealed Resident #6 continued to receive the 45 mg. dose of the Mirtazapine at bedtime. She reported the physician usually handed the recommendations to her or she retrieved the signed recommendation from the physician's binder. Nurse #1 explained the new dose should be implemented and did not know the reason it was missed. Interview with the Director of Nursing (DON) on 9/12/12 at 3:41 PM revealed she expected nursing staff to transcribe and implement the recommended medication change upon receipt of the signed physician's agreement. Interview with the physician on 9/13/12 at 8:30 AM revealed he expected the facility to implement his agreement with the pharmacist and direction for the GDR. 2. Resident #33 was admitted to the facility on 9/24/05 with diagnoses which included Hypothyroidism. Review of physician's orders dated 4/1/11 and updated monthly revealed an order to administer Synthroid 50 mcg. (micrograms) daily. (Synthroid is a medication used for thyroid hormone replacement.) A physician's order dated 7/9/11 directed a TSH (Thyroid Stimulating Hormone) and a T4 (Free Thyroxine) blood test to be obtained every 6 months during the months of February and August. (TSH and T4 are blood tests which	F 329	distribute recommendations to RN Unit Manager and LPN Unit Coordinator for recommendations to be communicated to physician and orders implemented accordingly. DON will ensure recommendations were implemented by auditing one week after physician has addressed them. RN Unit Manager, LPN Unit Coordinator or designee will monitor labs on a weekly basis to ensure accurate labs are obtained for 4 weeks then monthly. Director of Nursing (DON) and SDC provided in service education for licensed nurses beginning 09/12/2012 regarding the notification and implementation of pharmacy recommendations for dosage reductions and labs. 4.Director of Nursing will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 329	Continued From page 9 measure the levels of the thyroid hormone and are used to adjust the dosage of Synthroid.) Review of Resident #33's laboratory results dated 2/8/12 revealed a TSH level of 1.81 milli-international unites per liter (MIU/L) with a reference range of 0.40 to 5.50 MIU/L and a T4 level of 1.0 nanograms per deciliter (ng/dL) with a reference range of 0.89 to 1.76 ng/dL. Review of monthly physician's orders dated 8/1/12 revealed an order for Resident #33 to continue the Synthroid 50 mcg. (micrograms) daily. Review of Resident #33's clinical record revealed there were no August TSH and T4 available for review. Interview with Nurse #1, unit manager, on 9/13/12 at 8:20 AM revealed requisition slips were not completed for Resident #33's August thyroid levels so the test were not done. Nurse #1 provided no explanation for the omission of the laboratory tests. Interview with Resident #33's physician on 9/13/12 at 8:30 AM revealed the ordered TSH and T4 laboratory tests were necessary to monitor Resident #33's thyroid medication dosage. Interview with the Director of Nursing (DON) on 9/13/12 at 11:00 AM revealed she expected the nursing staff to prepare laboratory requisition slips in order to ensure completion of physician's orders.	F 329		

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F 329	Continued From page 10 3. Resident #86 was admitted to the facility in April 2011 with diagnoses including Senile Delusion and Depressive Disorder, among others. Review of the pharmacist's consultant reported dated 3/6/12 revealed a recommendation to the physician for a gradual dose reduction (GDR) of either antipsychotic: Risperidone .5mg at bedtime or Seroquel 150 mg at bedtime. The physician signed and accepted the recommendation on 3/14/12 stating to decrease the Risperidone to .25 mg at bedtime. Review of the pharmacist's consultant report dated 4/16/12 revealed a comment stating the physician accepted the recommendation to decrease the Risperidone to .25 mg at bedtime on 3/14/12. The pharmacist requested the order be processed and the medical record updated accordingly. Review of Resident #86's medical record revealed medication administration records from April 2012 - May 2012 that documented Resident #86 continued receiving Risperidone .5mg at bedtime until 5/31/12. During an interview with Nurse #1, unit manager, on 9/13/12 at 9:21 AM she reported the nurse who received the physician's order would have been responsible for making sure the order was transcribed. She was unable to determine which nurse received the order.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of	F 333		

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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 333	Continued From page 11 any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to administer Vitamin D 3 as ordered by the physician for one (1) of ten (10) sampled residents reviewed for medications (Residents #6). The findings are: Resident #6 was admitted to the facility with diagnoses which included Quadriplegia and a Chronic Sacral Wound. Review of a physician's order dated 12/29/11 revealed direction to administer Vitamin D3 50,000 units monthly. Review of Resident #6's Medication Administration Records (MAR) from January 2012 to August 2012 revealed the Vitamin D3 was scheduled to be administered during the 7:00 AM to 3:00 PM shift on the 29th of the month. Further review of Resident #6's MARs revealed six months without documentation of the Vitamin D3 administration (February 2012, April 2012, May 2012, June 2012, July 2012 and August 2012). Interview with Nurse #2 on 9/12/12 at 3:10 PM revealed medications scheduled on a monthly basis during the day shift would be administered with the morning medication pass. Nurse #2 reported she did not remember if the monthly	F 333	F 333 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 6. Director of Nursing (DON) provided in service education for licensed nurses beginning September 12, 2012 regarding the policy and procedure for "Medication management; Administering medications as ordered." Licensed nurse notified physician regarding alleged missed doses of Vitamin D. No new orders given. 2. Current residents have the potential to be affected by the same alleged deficiency. DON, LPN Unit Coordinator and RN Unit Manager conducted an audit on 9/12/12 of current facility residents Medication Administration Record (MAR) to identify omitted or missed medications. Licensed nurse notified physician regarding discrepancies identified. DON/SDC provided in service education for licensed nurses beginning September 12, 2012, regarding the policy and procedure for "Medication management; Administering medications as ordered." **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012

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F 333	Continued From page 12 Vitamin D3 had been administered. Nurse #2 explained she initialed the MAR after medication administration. Interview with Nurse #1, unit manager, on 9/12/12 at 3:14 PM revealed nurses used the over the counter medication stock supply for Vitamin D3 administration. Nurse #1 reported she did not know if Resident #6 received the monthly Vitamin D3. Interview with the Director of Nursing (DON) on 9/12/12 at 3:41 PM revealed she expected nurses to initial the MAR after medication administration. The DON reported she could not determine if the medication was administered unless the nurse initialed the MAR.	F 333	3. The following measures have been out into place to ensure that the deficient practice does not reoccur. Director of Nursing (DON) provided in service education for licensed nurses beginning September 12, 2012 regarding the policy and procedure for "Medication management; Administering medications as ordered." RN Unit Manager, LPN Unit Coordinator or designee will audit MAR's to ensure that ordered medications are documented on MAR and administered as ordered, weekly for 4 weeks then monthly for 2 months. 4. Director of Nursing will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, inteviews with staff and review of facility records, the facility failed to monitor and maintain the wash/rinse cycle temperatures of the high temperature sanitizing dish machine per manufacturer	F 371	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 371	Continued From page 13 recommendations for two (2) of two (2) observations. The findings are: The facility's policy, untitled and undated, recorded in part the following, "Minimum Temperatures Using High-Temperatrue Sanitizing, Single-Tank Models, Wash Tank 160 (sign for degrees) F, Final Rinse 180 (sign for degrees) F." An observation of the high temperature dish machine, while in use, occurred on 9/10/12 at 7:01 AM. Dietary staff #1 was observed washing six insulated cups, one large stainless steel bowl, one wire whisk, five forks, five spoons, seven knives, four fluted dessert bowls, and two insulated bowls. The dish machine temperatures for the wash cycle was 164 degrees F and the rinse cycle was was 176 degrees F. These dishes were observed stored on a rack to dry after being washed. Review of the September 2012 dish machine temperature log, posted above the hand sink, revealed wash/rinse cycle temperatures were not recorded for September 8-10, 2012. The log also posted the minimum temperatures for the wash cycle as 160 degrees F, the rinse cycle as 180 degrees F and that staff should report concerns to the manager. A second observation of the dish machine, while in use, occurred on 9/12/12 at 10:44 AM. Dietary staff #2 was observed washing two stainless steel sheet pans. The wash cycle was observed to be 150 degrees F and the rinse cycle was observed	F 371	effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 371	Continued From page 14 to be 160 degrees F. An interview with dietary staff #2 on 9/12/12 at 10:45 AM while he used the dish machine revealed that he just started using the dish machine and did not check the temperature of the wash/rinse cycles to ensure the temperarures were hot enough. Dietary staff #2 also confirmed that the dishes from breakfast that morning had already been washed and stored to dry. An interview on 9/12/12 at 10:48 AM with the certified dietary manager (CDM) revealed that to his knowledge, the dish machine worked without problems yesterday and that morning. Observation of the dish machine, while in use, during the interview with the CDM revealed the wash cycle was 160 degrees F and the rinse cycle was 170 degrees F. An interview on 9/12/12 at 10:50 AM with dietary staff #1 revealed he did not report the low temperature of the rinse cycle of the dish machine on 9/10/12 to the CDM. He further stated that he did not check the temperature of the wash/rinse cycles of the dish machine before he started sending dishes through. During a follow-up interview with the CDM on 9/12/12 at 11:00 AM, he stated that he was not informed that the dish machine rinse cyle was not reaching 180 degrees F on 9/10/12 by staff. He would expect staff to inform him if the wash/rinse cycles were not hot enough. The CDM also stated that the minimum wash/rinse cycle temperatures for the dish machine should be 160/180 degrees F and that the minimum temperatures were posted for staff reference.	F 371	F 371 1) Corrective action has been accomplished for the alleged deficient practice in regards to facility failed to monitor and maintain the wash/rinse cycle temperatures per manufacturers recommendations. Dietary Manager provided in-service education beginning September 12, 2012 for Dietary staff, regarding monitoring wash/rinse cycle temperatures before and while dish machine is in use. Dietary Manager reported on September 12, 2012 fluctuations in wash/rinse temperatures outside the acceptable range to the Maintenance Director. Maintenance Director turned the booster (heating element) power switch on/off switch to reset dish machine on September 12,2012. 2) Residents have the potential to be affected by the same alleged deficiency. Dietary Manager and Maintenance Director began to observe Wash/Rinse temperatures of the dish machine daily on September 12, 2012 to assure temperature accuracy per manufacturers recommendations. Discrepancies were corrected when identified. 3)Measures put into place to ensure that the alleged deficient practice does not **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012

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

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F 371	Continued From page 15 The CDM also confirmed that the breakfast dishes from that morning had all been washed and stored to dry. On 9/13/12 at 7:55 AM, maintenance staff #1 was interviewed and stated that on 9/12/12 he was called to the kitchen, around 11:00 AM, by the CDM regarding the dishmachine. Maintenance staff #1 stated that he found that the temperature of the dishmachine was not hot enough for the rinse cycle, so he turned the booster (heating element) power switch on/off to reset it. He also stated whenever there was a problem with the dishmachine, the kitchen staff contacted him and if it was a temperature issue he would reset the booster first. He revealed that he was not made aware of any concerns with the temperature of the dish machine before 9/12/12 around 11:00 AM.	F 371	recur includes: Dietary Manager provided in-service education beginning September 12, 2012 for Dietary staff, regarding monitoring wash/rinse temperatures of the dish machine per manufacturers recommendations. Dietary Manager and Maintenance Director will observe dish machine wash/rinse temperatures daily for 2 weeks then 3 times per week for 2 weeks then weekly ongoing to assure accuracy of wash/rinse temperatures per manufacturers recommendations. 4)Dietary Manager and Maintenance Director will analyze wash/rinse dish machine temperature monitoring logs for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.	
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 observation, interview and record	F 412	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 412	Continued From page 16 review, the facility failed to administer a sedative in order to provide dental services for one (1) of three (3) sampled residents reviewed for dental services (Resident #27). The findings are: Resident #27 was admitted to the facility with diagnoses which included Alzheimer's Disease. Review of physician's orders dated 6/12/12 revealed direction to administer the sedative, Halcion 0.125 mg (milligrams) 45 minutes prior to dental appointments. Review of an electronic mail (email) message to the facility's social worker dated 7/27/12 revealed a dental appointment scheduled for Resident #27 at 10:20 AM on 8/7/12. Review of a dental consult dated 8/7/12 revealed Resident #27 could not be seen due to the unavailability of the sedative medication and that the prophylactic dental treatment would be rescheduled for October 12, 2012. Review of Resident #27's August 2012 Medication Administration Record (MAR) revealed there was no documentation of Halcion 0.125 mg administration. Interview with Nurse #1 on 9/12/12 at 4:57 PM revealed Resident #27 could not be seen by the dentist on 8/7/12 because the Halcion was not available. Nurse #1 could not provide a reason for the unavailability of the medication. Interview with Nurse #3, on 9/13/12 at 10:10 AM	F 412	F 412 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 27. Director of Nursing (DON) provided in service education for licensed nurses beginning September 12, 2012 regarding the policy and procedure of licensed nurses ensuring that residents have sedatives as ordered prior to scheduled procedures. Social Worker contacted dentist for follow up appointment for resident #27. Appointment was made for October 23, 2012. 2. Current residents have the potential to be affected by the same alleged deficiency. Director of Nursing (DON) and Social Worker (SW) identified current facility residents with upcoming appointments that require medication prior to appointment. DON assured medication was available for residents identified. DON/SDC provided in service education for licensed nurses to ensure residents receive sedatives prior to being treated by outsourced physicians beginning September 13, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012

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F 412 Continued From page 17

revealed she did not have the Halcion available to administer to Resident #27. Nurse #3 explained she did not know of Resident #27's dental appointment until the morning of 8/7/12. Nurse #3 explained the Halcion required the physician to write a hard prescription before the medication could be ordered from the pharmacy. Nurse #3 reported it would take too long to obtain the medication so Resident #27 did not have the dental appointment that day.

Interview with the Social Worker (SW) on 9/13/12 at 11:50 AM revealed she informed the nursing department of Resident #27's dental appointment on 8/7/12.

During an interview with the Director of Nursing (DON) on 9/13/12 at 3:15 PM, the DON explained Resident #27's dental appointment cancellation was because the nurses did not know of the appointment until that day (8/7/12).

F 428 SS=E 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:

F 412

3. The following measures have been put into place to ensure that the deficient practice does not reoccur. Social Worker Director will give DON, RN Unit Manager and LPN Unit Coordinator a copy of the scheduled appointments for the current facility residents that will be seen from outsourced physicians. The manager/coordinator will ensure that sedatives are available on the medication cart at least three days prior to scheduled appointment. The RN Unit Manager and LPN Unit Coordinator will conduct an audit for sedatives one week prior to appointments ongoing. DON/SDC provided in service education for licensed nurses to ensure residents receive sedatives prior to being treated by outsourced physicians beginning September 13, 2012.

F 428

4. Director of Nursing will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness

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F 428	Continued From page 18 Based on observation, staff, physician and pharmacist interviews, and record review, the facility failed to refer the pharmacist's recommendations for Gradual Dose Reductions of psychoactive medication to the physician for four (4) of ten (10) sampled residents (Residents # 6, #33, #76 and #28). The findings are: 1. Resident #6 was admitted to the facility on 7/13/11 with diagnoses which included Depression. Review of physician's orders dated 7/13/11 revealed direction to administer Mirtazapine 45 mg. (milligrams) at bedtime. (Mirtazapine is a medication used to treat Depression.) Review of the physician's monthly orders dated 8/8/12 revealed orders to continue the bedtime administration of Mirtazapine to Resident #6. Review of the pharmacist's consultant report dated 5/21/12 revealed a recommendation to the physician for a gradual dose reduction (GDR) of Mirtazapine (an antidepressant) from 45 mg. (milligrams) to 30 mg, at bedtime. The physician accepted the recommendation and signed the report on 5/31/12. The physician did not indicate a different dose for the Mirtazapine. Review of pharmacy progress notes dated 8/15/12 revealed documentation of physician acceptance of the GDR without specific indication of dosage. Review of the physician's signed acceptance of	F 428	of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 428	Continued From page 19 the GDR for the Mirtazapine dated 9/5/12 specified the dose be decreased to 15 mg. at bedtime. Interview with Nurse #1, unit manager, on 9/12/12 at 3:14 PM revealed Resident #6 continued to receive the 45 mg. dose of the Mirtazapine. She reported the physician usually handed the pharmacist's recommendations to her or she retrieved the signed recommendation from the physician's binder. Nurse #1 explained the new dose should be implemented and did not know the reason the first recommendation on 5/31/12 did not receive clarification by the physician until 9/5/12. Interview with the physician on 9/13/12 at 8:55 AM on 9/13/12 revealed he would expect to receive the pharmacist's recommendation within a week. The physician reported he came to the facility twice weekly and relied on the facility to forward the pharmacist's recommendations. Interview with the pharmacist on 9/13/12 at 10:35 AM revealed he placed his recommendations into a website for retrieval by the Director of Nursing (DON). He explained he would inform her by electronic mail (email) of the recommendations readiness for download. The pharmacist reported he did not directly contact the physician and relied on the facility to forward his recommendations. He explained he would wait two months for the physician to respond. The dose clarification would be addressed by the facility. The pharmacist reported he would reissue the recommendation and inform the DON by email and orally.	F 428	F 428 1)Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 6, 28 and 33, GDR (gradual drug reduction) of antidepressant medication according to pharmacy recommendations. Licensed nurse notified physician on September 12, 2012 regarding pharmacy recommendations for dosage reduction of medication. New orders received and implemented. Corrective action has been accomplished for the alleged deficient practice in regards to Resident # 76 in regards to GDR (gradual drug reduction) of psychotropic medication. Licensed nurse notified physician regarding pharmacy recommendations for dosage reduction of medication. New orders received and implemented. Director of Nursing (DON) provided in service education for licensed nurses beginning 09/12/2012 regarding the notification and implementation of pharmacy recommendations for dosage reductions. 2. Current residents have the potential to be affected by the same alleged deficiency. DON, LPN Unit Coordinator and RN Unit Manager conducted an audit of current **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	10-12-2012

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F 428	Continued From page 20 Interview with the DON on 9/13/12 at 11:02 AM revealed she received an email from the pharmacist when the recommendations were ready to download. The DON explained she would print out the recommendations and place them into the physician's binder on each nursing unit. The DON reported it was the facility's responsibility to forward the pharmacist's recommendations to the physician. The DON added she identified this delay was not acceptable. 2. Resident #76 was admitted to the facility with diagnoses which included Schizophrenia. Physician ordered admission medications dated 10/18/11 included Clozaril 200 mg. (milligrams) twice daily for treatment of Schizophrenia. Review of the pharmacist's recommendation dated 6/13/12 revealed a recommendation to consider a Gradual Dose Reduction (GDR) of the Clozaril. Review of the pharmacist's recommendation dated 9/10/12 revealed a repeated recommendation for a GDR of Clozaril. Interview with Nurse #1, unit manager, on 9/12/12 at 3:14 PM revealed the pharmacist's recommendations were placed into the physician's binder at the nursing station by nursing administration. Nurse #1 explained the physician usually handed the recommendations to her or she retrieved the signed recommendation from the physician's binder. She reported she did not know the reason of the delay in the physician's response to the recommendation.	F 428	facility residents that have had pharmacy recommendations within the last 30 days for GRD (gradual drug reductions.) DON, LPN Unit Coordinator and RN Unit Manager conducted an audit beginning September 12, 2012. Licensed nurse notified physician regarding pharmacy recommendations and orders were implemented. 3.Measures put into place to ensure that the alleged deficient practice does not recur includes: Pharmacist will provide a consultant recommendation report to the DON each month. The DON will distribute recommendations to RN Unit Manager and LPN Unit Coordinator for recommendations to be communicated to physician and orders implemented accordingly. DON will ensure recommendations were implemented by auditing one week after physician has addressed them. RN Unit Manager, LPN Unit Coordinator or designee will monitor labs on a weekly basis to ensure accurate labs are obtained for 4 weeks then monthly. Director of Nursing (DON) and SDC provided in service education for licensed nurses beginning 09/12/2012 regarding the notification and implementation of pharmacy **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 428	Continued From page 21 Interview with the physician on 9/13/12 at 8:55 AM on 9/13/12 revealed he would expect to receive the pharmacist's recommendation within a week. The physician reported he came to the facility twice weekly. Interview with the pharmacist on 9/13/12 at 10:35 AM revealed he placed his recommendations into a website for retrieval by the Director of Nursing (DON). He explained he would inform her by electronic mail (email) of the recommendations readiness for download. The pharmacist reported he did not directly contact the physician and relied on the facility to forward his recommendations. He explained he would wait two months for the physician to respond. The pharmacist reported he would reissue the recommendation and inform the DON by email and orally. Interview with the DON on 9/13/12 at 11:02 AM revealed she received an email from the pharmacist when the recommendations were ready to download. The DON explained she would print out the recommendations and place them into the physician binders on each nursing unit. The DON reported it was the facility's responsibility to forward the pharmacist's recommendations to the physician. The DON added she identified this delay in the Clozaril recommendation for Resident #76 was not acceptable. 3. Resident #33 was admitted to the facility on 9/24/05 with diagnoses which included Depression.	F 428	recommendations for dosage reductions and labs. 4. Director of Nursing will analyze audits for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING ______ B. WING ______	C 09/14/2012

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F 428	Continued From page 22 Review of physician's orders dated 2/21/12 revealed Zoloft (an antidepressant) 150 mg. daily was to be administered to Resident #33. Review of the pharmacist's consultant report dated 7/9/12 revealed a recommendation to consider a Gradual Dose Reduction (GDR) of Zoloft. Review of pharmacy progress notes dated 8/15/12 revealed the pharmacist documented intent to follow the lack of physician response to GDR recommendation. Review of the pharmacist's consultant report dated 9/10/12 revealed a recommendation to consider a GDR of Zoloft which was accepted by the physician on 9/13/12. Interview with Nurse #1, unit manager, on 9/12/12 at 3:14 PM revealed the pharmacist's recommendations were placed into the physician's binder at the nursing station by nursing administration. Nurse #1 explained the physician usually handed the recommendations to her or she retrieved the signed recommendation from the physician's binder. She reported she did not know the reason of the delay in the physician's response to the recommendation. Interview with the physician on 9/13/12 at 8:55 AM on 9/13/12 revealed he would expect to receive the pharmacist's recommendation within a week. The physician reported he came to the facility twice weekly. Interview with the pharmacist on 9/13/12 at 10:35	F 428		

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

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F 428	Continued From page 23	F 428		

AM revealed he placed his recommendations into a website for retrieval by the Director of Nursing (DON). He explained he would inform her by electronic mail (email) of the recommendations readiness for download. The pharmacist reported he did not directly contact the physician and relied on the facility to forward his recommendations. He explained he would wait two months for the physician to respond. The pharmacist reported he would reissue the recommendation and inform the DON by email and orally.

Interview with the DON on 9/13/12 at 11:02 AM revealed she received an email from the Pharmacist when the recommendations were ready to download. The DON explained she would print out the recommendations and place them into the physician on each nursing unit. The DON reported it was the facility's responsibility to forward the pharmacist's recommendations to the physician. The DON added she identified this delay was not acceptable.

4. Resident #28 was admitted to the facility December 2005 with diagnoses including Diabetes Mellitus Type II-uncontrolled, Hypertension, and Depression.

Review of the pharmacist's consultant report dated 5/16/12 revealed a recommendation to the physician for a gradual dose reduction (GDR) of Remeron (an antidepressant) 30 mg daily for management of appetite/depressive symptoms.

Review of pharmacy progress notes dated 7/9/12 revealed documentation to reissue the GDR

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F 428	Continued From page 24 request in August 2012 if there had been no response. Review of the pharmacist's consultant report dated 8/15/12 revealed a repeated recommendation from May 2012. The pharmacist requested a prompt response of the GDR recommendation of Remeron 30 mg daily for Resident #28. The physician signed the report on 8/29/12 declining the recommendation, stating Resident #28 still presented with depressive symptoms. Interview with the physician on 9/13/12 at 8:55 AM revealed he would expect to receive the pharmacist's recommendation within a week. The physician reported he came to the facility twice weekly. Interview with the pharmacist on 9/13/12 at 10:41 AM revealed he placed his recommendations into a website for retrieval by the Director of Nursing (DON). He explained he would inform her by electronic mail (email) of the recommendations and verbally before exiting the facility. He explained he would give two months for the physician to respond, then he would inform the DON that there had been no response and reissue the recommendation. In an interview with the Director of Nursing at 2:40 PM on 9/13/12 she stated when the pharmacist made a recommendation she would print it and put it in the physician's book. She stated if the recommendation was reissued it would appear that the pharmacist did not see the first recommendation that the physician signed. She went on to say that if the original recommendation	F 428		

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F 428	Continued From page 25 was signed and reviewed by the physician it should be in Resident #28's record as well. She was unable to supply a signed pharmacy recommendation for 5/16/12.	F 428		