PRINTED: 10/04/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION OCT 17 2012 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 09/20/2012 345262 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1300 DON JUAN ROAD **BRIAN CENTER HEALTH & REHAB/HE** HERTFORD, NC 27944 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES OMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 000 F 000 INITIAL COMMENTS No deficiencies were cited as a result of a "Preparation and /or executation of this plan of complaint investigation conductued 09/17/12 to correction does not constitute admission or agreement by the provider of the truth of the facts 09/20/12, Event ID # 9YEP11. alleged or conclusions set forthin the statement of F 246 483.15(e)(1) REASONABLE ACCOMMODATION F 246 deficiencies. The plan of correction is prepared OF NEEDS/PREFERENCES and/or executed solely because it is required by the SS=D provisions of federal and state law." A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and F-246 preferences, except when the health or safety of the individual or other residents would be 1. Corrective action has been endangered. accomplished for the alleged deficient practice in regards to Resident #35 call bell in place and This REQUIREMENT is not met as evidenced functioning 9/20/12 bv: Based on observations, record reviews, and staff interviews the facility failed to position call bell 2. Facility residents who have the equipment in reach of 1 of 40 (resident #35) potential to be affected by the same sampled residents. alleged deficient practice were Findings include: evaluated on 9/20/12 to assure each A review of resident # 35 medical record revealed had a functioning call bell located Resident #35 had a fall at the facility on 2/14/12 within reach. resulting in a hip fracture. A surgical repair was done at the hospital and resident #35 returned to

The 30 day Minimum Data Set (MDS) dated

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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LABORATORY DIRECTOR SIGNATURE

LABORATOR SIGNATURE

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the facility on 2/20/12. Resident #35 was readmitted to the hospital on 7/19/12 for a total hip replacement due to failure of the original orthopedic fixation. Resident #35 was readmitted

to the facility on 7/24/12 after a total hip replacement. Other diagnoses for resident #35 include macular degeneration, arthritis, and

10/13/12

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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(X6) DATE

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F 246	Continued From page 8/21/12 indicated recognitively impaired Resident #35 was a known and usually #35 required extens to illeting, dressing, An observation on resident #35 was a positioned between The call bell was pon her bed. An observation on wheelchair reveale were in use. Fall afloor on both sides was nearest to the pressure air mattr of the bed; coiled from the end of the room. During an interview of the had breakfast an Resident #35 the had breakfast an Resident #35 incomplete wheelchair revealed resider needs known ar call for assistant used to be a fall now. NA #2 incomplete in the presonal alarment of the service of a falls risk still personal alarment.	ge 1 sident #35 was moderately for decision making. sually able to make her needs understood others. Resident sive assistance for hygiene, and ambulation. 9/20/12 at 10:20 AM revealed itting in a wheelchair in the two beds in her room. ositioned behind the resident servation of resident #35 's ed 2 personal alarm devices mats were positioned on the sof resident #35 's bed which door. Cords from the low ess were positioned at the end and protruding about one foot use bed near the doorway of the ew on 9/20/12 at 10:20 AM resident indicated she had just d was resting in her chair. licated she did not see well. 0:30 AM an interview with NA #2 indicated she had just d was able to make her id was able to use her call light to ce. NA # 2 indicated resident #35 is risk and was unsure if she was licated that resident #35 was sort ill since they use a low bed, s and fall mats. NA #2 indicated ring for resident #35 today but had er a lot of times and was familiar	F	= 246	3. Systemic Measures put place to assure that the sar alleged deficient practice recur include: Re-education Certified Nursing Assista 10/12 regarding placement bell and will continue und complete by the Staff Derection on 10/11 regard bell placement and will complete by the Din Nursing. Ambassadors we ducated on 10/8 by the administrator regarding placement and monitoring placement. Director of 1 Staff Development Coordinator/designee to bell placement on 5 resistant x 2 weeks then 5 reweekly x 2 weeks then 5 residents month months.	does not on of ont of call il velopment taff reding call continue ector of were recall belling for Nursing, audit call dents every esidents	to cheet Page

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F 246	resident #35 remain room and her call be her reach. On 9/20/12 at 10:50 resident #35 's room snack and assisted reposition herself in the state of	AM an observation revealed hed in her wheelchair in her ell was not positioned within O AM Nurse #5 entered of an and offered the resident a resident #35 to stand to he wheelchair. O/12 at 10:55 AM with Nurse as the nurse caring for resident #35 was able to use her call bell ds known. O/12 at 11:00 AM revealed will light was not in reach. O/12 at 11:00 AM with NA#3 caring for resident #35 today in the 200 hall and the 300 aled resident #35 needed total of Daily Living and resident #35 wher needs. NA # 3 revealed id call out if she needed A # 3 indicated resident #35 had a seat belt for fall he staff would try to get resident #35 and try to toilet resident #35 every so resident #35 would not try to her own.	F	: 24	4. The Director of nursi review the audits analyz and report patterns and the Quality Assessment Assurance Committee in The committee will evaluate effectiveness of the plan outcomes. Additional interventions will be detended the committee and impleassure continued complete.	trends to and nonthly x 3. luate the based on veloped by emented to	11/3/12
	1.1 405 101	1:25 AM DON and NA#3 entered room and shut door. At 11:45 AM served to be dressed (had been in				le ambientation	n sheet Page 3

ENTERS	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SUR COMPLETE	D
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E 246	On 9/20/12 at 12:0 a staff member retirement resident #35 with wheelchalr between in reach of resident positioned on resident positioned on resident positioned on resident resident #35 's be indicated she would be provide the provided by the provided prov	oph an observation revealed urned resident #35 to her room was positioned seated in her en the beds with the call bell not at #35. The call bell was dent #35's bed. O5 PM an interview with Nurse ent #35 should have had her call where it was positioned on ed was not in reach. Nurse #5 ald reposition the call light. ation on 9/20/12 at 12:07 PM ted resident #35 to the use of the set #35 was able to demonstrate	F 246			
F 31 SS=	she knew what the An interview on State DON and the Reserve aled they we reach of resident 483.25(a)(3) ADDEPENDENT Resident who daily living recemaintain good rand oral hygien. This REQUIRE	L CARE PROVIDED FOR ESIDENTS is unable to carry out activities of ives the necessary services to nutrition, grooming, and personal	F 312			ion sheet Page

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		E CONSTRUCTION	COMPLETE	ED
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F 312	record reviews, the fit toileting needs for 1 residents who require Findings included: Resident #90 was a with diagnoses to inglaucoma. The resident's admit (MDS) of 7/23/12 reextensive assistance transfer, dressing, a indicated the reside assistance of 1 staff hygiene. The reside incontinent of bowel Review of the reside revealed a problem requires staff assist completion of (Active Requires extensive members. Care plate Offer/assist to toilet Observation of the AM revealed the recon his right side with body to his neck. The around the resident area of the bottom in noted and extended and from the resident edges from 10 o'clothorown. The resident resident edges from 10 o'clothorown.	facility failed to assist with (Resident #90) of 7 sampled red assistance with toileting. Idmitted to the facility 7/16/12 clude Dementia and Inside the resident required red of 2 plus staff members for red toileting. The assessment int required extensive If member for personal rent was assessed as always	F	312	"Preparation and for executation of the correction does not constitute admissions agreement by the provider of the truth alleged or conclusions set forthin the deficiencies. The plan of correction is and/or executed solely because it is reprovisions of federal and state law." 1. Corrective action has be accomplished for the alleged deficient practice in regard. Resident # 90 by assisting to to maintain personal hygiene.	on or h of the facts statement of sprepared quired by the een ed ds to	

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F 312	curtain was pulled at the bed. The residen name was called ar remained on his right. During an observation of Nursing AM, the resident rested had been wet for a resident 's brief replace. During an interview #2 on 9/20/12 at 1 resident didn't urin brief aside, pulled urinated while in the resident was contibathroom. The rebed and assisted During an observation of the bed and 3/4; so the bed and 3/4; so the mattress had under the sheet at the bed she last of breakfast about the NA stated she day, she didn't net the she charted and she she is the she charted and she she she is the she charted and she she she is the she charted and she she is the she charted and she she she she is the she she she she she she she she she s	cross the resident 's foot of nt roused slightly when his d repositioned himself, but	F	2. Facility residents incontinent and required with toileting have be affected by the deficient practice. Care Management residents who trigging incontinence who their bladder and han audit on 9/25/1 identified were evinterdisiplinary tea toileting plan if New admissions by the interdiscip Residents will be admission, quarte with significant cutilizing the Bow evaluation tool.	the potential to same alleged. The Resident Director for ger for low risk lose control of cowel completed. The residents raluated by the am to determine appropriate. will be evaluated linary Team. evaluated on crly, annually and change of status, rel and Bladder.	n sheet Page 6 of 27

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revealed the have been 483.25(b) HEARING To ensure and assist hearing at assist the by arrangi office of a treatment office of a provision of the provision of	ating break wwwith the he DON ex taken to the TREATME //ISION that reside ive devices bilities, the resident in ng for trans practitione of vision or UIREMEN' nobservation of vision or UIREMEN' nobservation of vision or UIREMEN' nobservation of vision or the control of vision or the deside for the quarte and orie about her the resider			312	3. Systemic Measures put in to assure that the same alle deficient practice does not include: Re-education of the Certified Nursing Assistant providing incontinent care toileting assistance will be provided beginning 10/12/continue until completion In Director on Nursing and the Development Coordinator. Licensed staff will be re-educated by the Director of Nursing 10/11/12 on the Bowel and Management System and continue until complete. The Director of Nursing, Staff Development Coordinators will randomly audit 3 residual that are dependent on toileting assistance to ensity toileting plan is effective tweeks, than 3 residents per 2 weeks, then 3 residents per 2 weeks, then 3 residents and the same toileting plan is effective to the same to t	ged recur he ts on and 12 and by the he Staff ducated on I Bladder will he /designee dent per staff for ure the x 2 er week x	

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F 313	Continued From parthe exception of bar which she needed assessment did incoglasses and needed. Review of the Care sheet did not rever a need for review. Review of an opht dated 04/19/12, in physician for dilate for non-proliferation (NPR is small are retina's tiny blood the resident's NP. There was a presiglasses that inclupart: "it is okay the counter) react On 09/19/12 at 1 observed for a dwas not observed. An interview, or conducted with had glasses she Medicaid no lor could not afforce. An interview, or conducted with who had recent indicated when glasses one of issue relayed the research of the conducted with the counter of the conducted with the conducted when glasses one of issue relayed the conducted when glasses one of issue relayed the conducted with the conducted when glasses one of issue relayed the conducted with the conducted when glasses one of issue relayed the conducted with	ge 7 thing and personal hygiene for only supervision. The licate the resident did not wear d large print for reading. Area Assessment (CAA) all vision had been identified as halmologist consultation visit, dicated Resident #9 saw the ation of her eyes as a follow up we diabetic retinopathy (NPR) as of balloon-like swelling in the exercise very exercise seription given to the resident for added the instructions that read in to use +3.25 (sphere) OTC (over thing glasses" 0:00 AM, Resident #9 was ressing change. The resident add to have glasses. 109/20/12 at 12:15 PM, was Resident #9. When asked if she a stated she did not because ager paid for glasses and she		313	4. The Director of Nursing review the audits analyze and report patterns and tree the Quality Assessment at Assurance Committee months assurance Committee will evaluate effectiveness of the plan outcomes. Additional interventions will be deverthe committee and imples assure continued compliants. F 313 "Preparation and for executation correction does not constitute adapteement by the provider of the alleged or conclusions set forthing deficiencies. The plan of correct and/or executed solely because it provisions of federal and state is 1. Corrective action accomplished for the deficient practice in Resident # 9 by acquiglasses.	the data ends to nd onthly x 3. late the based on eloped by mented to ance. I of this plan of mission or a truth of the fact the statement of the statement of the required by the control of the statement of the control of the statement of the	1

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	An interview, on 09 conducted with the (BOM). The BOM Medicaid stopped pover 21 years of agwhen a resident has would be asked if the BOM indicated if the facility would have rehave given the information when a sked if should have rehave given the information when the producted with North part of the producted with North part of the producted with Substantial was not able to producted with when the nurse with orders, the handle them as through until co	ge 8 20/12 at 5:50 PM, was Business Office Director relayed that in April of 2011 relaying for glasses for people ge. She went on to say that d a need for glasses the family hey could purchase them. The ne family can not and it is rects the resident 's quality of dd purchase. She indicated if ceived a request she would formation to the Administrator. It was aware of Resident #9 's was aware of Resident #9's when the stated she was not. 19/20/12 at 6:14 PM, was were #2. She relayed she was were seed and would not pay for the redicald would not pay for the deted the family was asked and way for them. She indicated she mat happened after that. 109/20/12 at 7:22 PM, was the DON. The DON relayed that received a consultation report nurse would be expected to any orders and follow them melleted. 100 PM. the Administrator	F	3131	2. Facility resident who a of eye glasses have the probe affected by the same a deficient practice. The So Worker completed an autophthalmology consults that all consultant recommendations for the 12 months have been addithe attending physician a orders required have been implemented. 3. Systemic Measures pulace to assure that the alleged deficient practice recur include: Licensed be re-educated on 10/1 Director of Nursing on for obtaining orders where the sum of the	lleged ocial dited on to validate e pervious dressed by and any en out into same ce does not l Staff will 1/12 by the the process nen a n eye will te. The n will review nsults turing the m morning	
F	approached an	d stated the facility was the facility was the facility was available.	And the second s	F 323	Ophthalmology recor	nmendations ated to the and any order	rs .
		st ensure that the resident emains as free of accident hazards			have been acted upor	1 X 3 IIIOIIII a	on sheet Page 9

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	Continued From page as is possible; and eadequate supervision prevent accidents. This REQUIREMENT by: Based on observation interviews the facility interventions to precidentified as cognition interventions inclubell equipment in releasing seat belt sampled residents. Findings include: A review of resident resident #35 had resulting in a hip done at the hospithe facility on 2/2 readmitted to the hip replacement orthopedic fixation to the facility on replacement. Off include macular dementia. The care plan demanded to the facility on replacement of the facility on replacement. Off include macular dementia.	each resident receives on and assistance devices to and assistance devices to an and assistance devices to a self tity failed to implement event falls for a resident stretch and the use of a self tor 1 of 40 (resident #35) and the facility on 2/14/12 fracture. A surgical repair was tall and resident #35 returned to 60/12. Resident #35 was hospital on 7/19/12 for a total due to failure of the original on. Resident #35 was readmitted 7/24/12 after a total hip ner diagnoses for resident #35 degeneration, arthritis, and ated 8/3/12 indicated resident #35 or falls with interventions which the hospide the bed, chair and bed	F 323	4. The Director of Nursing review the audits analyze to and report patterns and treation the Quality Assessment and Assurance Committee more of the committee will evaluate effectiveness of the plan be outcomes. Additional interventions will be dever the committee and implementation and for executation correction does not constitute admagreement by the provider of the alleged or conclusions set forthin deficiencies. The plan of correction and/or executed solely because it provisions of federal and state law. 1. Corrective action has accomplished for the allegicient practice in regressions and the state of the complished for the st	nds to ad nthly x 3. ate the based on cloped by mented to more. of this plan of tission or truth of the facts the statement of on is prepared is required by the v." s been cleged gards to the easing seat bed to the montion Record onitor every ming and	11/3/12
	alarms, and place resident was also cognition impair	cing the call bell in reach. The so identified for vision and rments.		reach on 9/20/12.		sheet Page 10 c

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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F 323	resident #35 had a far on the floor. An Interform dated 8/20/12 recalled a safety belt with by resident #35 while The 30 day Minimum 8/21/12 indicated resident #35 was used known and usually un #35 required extensive toileting, dressing, an was not coded for resident #35 slide the floor. The summa Team recommendation resident #35 in her with unattended. There with initiated on the form of whether the seat belt resident #35. An observation on 9/2 resident #35 was sitting positioned between the There was a light blatten and the observation of resident #35 positioned behind the observation of resident #35 revealed 2 personal according to the control of the co	aled on 8/17/12 at 9:25 AM II. Resident #35 was found disciplinary Post Fall Review wealed a new intervention as ordered and to be worn in the wheelchair. Data Set (MDS) dated dent #35 was moderately or decision making. Lally able to make her needs aderstood others. Resident assistance for hygiene, d ambulation. The MDS traint usage. Aled an Interdisciplinary Post indicated on 9/5/12 at 3: 50 out of the wheelchair onto any of the Interdisciplinary ons was not to leave neelchair in her room ere no new interventions or documentation indicating device was in use for 20/12 at 10:20 AM revealed and in a wheelchair ne two beds in her room. Next on resident #35 's lap evealed there was no seat is lap. The call bell was a resident on her bed. An	<u>L</u>	323	2. Facility residents at risk for have the potential to be affect the same alleged deficient procession of the reviewing the current fall rist assessment. The Director of Nursing/designee will validate interventions developed by interdisciplinary team and extremal they have been implemented documented on the care plant cardex and Medication Administration Record if incommendation in the care plant cardex and the card	eted by ractice. by sk ate the the nsue 1 and 1, care	

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ĺ	ROVIDER OR SUPPLIER		ID.	130 HE	T ADDRESS, CITY, STATE, ZIP CODE O DON JUAN ROAD RTFORD, NC 27944 PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL	DRRECTION (X5) N SHOULD BE COMPLETION	
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F 323	sides of resident #3 the door. Cords from attress were positive coiled and protrudir of the bed near the During an interview resident #35 the rehad breakfast and light blanket on her she did not see we On 9/20/12 at 10:3 resident #35 remaroom and her call her reach. The call her reach. The call her reach and assiste reposition herself resident #35 's rown as she was observed device in use and within reach. An interview on 8 #35 and resident and make her new ther assignments she was familiar indicated she reher shift as she revealed resident and make her resident as she revealed resident and resident and make her new there shift as she revealed resident and re	5's bed which was nearest to m the low pressure air ioned at the end of the bed; ag about one foot from the end doorway of the room. on 9/20/12 at 10:20 AM sident indicated she had just was resting in her chair with a lap. Resident #35 indicated ill. 55 AM an observation revealed ined in her wheelchair in her bell was not positioned within it bell was behind resident #35	F	323	3. Systemic Measures put in place to assure that the sam alleged deficient practice direcur include: Directed in servicing related to fall management using the accomplished Digital Versatile disk for curing the accomplete disk for curing the accomplete disk for curing and transfer, ambulation and accomplete disk involving mobility problems. In addition the I of Nursing will provide reducation to staff beginning the accomplete distribution of the I and continuing until continuing until continuing will focus on fall management to include the implementation and staff communication of interverse A falls risk assessment we completed on Admission, Quarterly, Annually and significant change in state facility residents. Interventions will be developed and implementations will be communicated to direct to by using the 24-hour repelectronic care Cardex. The state of the provided direct of the	epted itations t involve ceident Director ng on 10- mplete. e entions. vill be with us for ntions will nented for k by the Resident care staff ort and the The	sheet Page 12

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	(X2) MU	LTIPLE	CONSTRUCTION	(X3) DATE SURV COMPLETED	EY
TATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILT			C	
•••		345262	B. WNG			09/20/	2012
		AB/HE TATEMENT OF DEFICIENCIES DAMEST BE DRECEDED BY FULL	ID PREFI	130 HE X	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPR	JLU 65 1	(X5) COMPLETION DATE
F 323	Continued From pagindicated resident # when she went into and she would checare plan to see if the for resident #35. An observation 9/2 resident #35's calcall bell was position bed. An observation revealed 2 personal fall mats were possides of resident # the door. Cords from the bed near the An interview on 90 indicated she was and was assigned hall. NA #3 revealed resident #35 would let you know resident #35 would let you know revealed resident #35 would not know the revealed resident #35 to activities would not try to indicated she would keep object and she would keep object in the state of the state o	LSC IDENTIFTING IN COMME	F	323	Director of Nursing/design audit 5 resident daily x 2 withen 5 resident monthly x who are at risk for falls to that interventions are in ple communicated to direct cannot be audits analyzed and report patterns and the Quality Assessment at Assurance Committee will evaluate effectiveness of the plan outcomes. Additional interventions will be developed the committee and imple assure continued complications.	nee, will weeks, 2 weeks 2 months validate lace and are staff. Ing will the data lends to and onthly x 3. Late the based on reloped by emented to ance.	11/3/12

TEMENT OF	DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		ONSTRUCTION	COMPLE	C
D PLAN OF C	CORRECTION		B. WING			09/	20/2012
AME OF PRO	OVIDER OR SUPPLIER	345262		1300	ADDRESS, CITY, STATE, ZIP CODE DON JUAN ROAD		,
BRIAN CEI	NTER HEALTH & REHA	AB/HE		HER	TFORD, NC 27944 PROVIDER'S PLAN OF CORRE	CTION	(X5)
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	Continued From pa #35 was usually more usually made attern wheelchair. On 9/20/12 at 11:2 entered resident #31:45 AM resident (had been in night to an activity. On 9/20/12 at 12:0 staff member returned resident #35 wheelchair between in reach of reside positioned on result on 9/20/12 at 12 #5 revealed resident #35 she indicated she would be with the work of the	ge 13 ore active in the afternoon and opts to get up out of her 5 AM the DON and NA#3 35 's room and shut door. At #35 observed to be dressed gown) and bought resident #35 OPM an observation revealed a rned resident #35 to her room was positioned seated in her en the beds with the call bell not in #35. The call bell was ident #35 's bed. OS PM an interview with Nurse dent #35 should have had her call where it was positioned on bed was not in reach. Nurse #5 ould reposition the call light. Vation on 9/20/12 at 12:07 PM on the dresident #35 to the use of the call bell two times and indicated the call bell was for.	L.	323			
	and the Region would expect the resident #35. was able to mat does not like to	al Nurse Consultant reveals and the call bell to be in reach of The DON indicated resident #35 ke her needs known and at times a come out to activities. The DON ent #35 would come out to the n and the staff was able to more					

SAME OF PROVIDER OR SUPPLIER 345282 STREET ADDRESS, CITY, STATE, ZIP CODE 3300 ON JUAN ROAD HERTFORD, NO. 27944 HERTFORD, NO. 27944 HERTFORD, NO. 27944 HERTFORD, NO. 27944 PREFIX TAG SS=D SS	ENTERS	FOR MEDICARE & I	MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURV COMFLETEE)
ME OF PROVIDER OR SUPPLIER NAN CENTER HEALTH & REHAB/HE STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DUN JUAN ROAD HERTFORD, NC 27944 PROVIDERS PLANT CORRECTION RECOLATORY ON LIES TERMINIST PRECEDED BY FULL RECOLATORY ON LIES THE PROPERTY TAGS SS=D F 329	ATEMENT OF D PLAN OF C	DEFICIENCIES ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		- I	(2042
RIAN CENTER HEALTH & REHABINE 1389 DON JUAN ROAD RETFORD, NC 27944			345262		70,000	09/20/	12012
PREPIX TAG SUBMENT STATEMENT OF DEPLOIDENCE SUBMENT STATEMENT OF DEPLOIDENCE SECRECATION MAST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F329 483.25(I) DRUG REGIMEN IS FREE FROM UNINCESSARY 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 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 staff interviews and record reviews, the facility failed to monitor 1 (Resident #22) of 8 sampled residents requiring monitoring for abnormal involuntary movements. Findings include: F329	AME OF PRO	VIDER OR SUPPLIER		1:	300 DON JUAN ROAD		
PREFIX TABLE STATEMENT OF DEFICIENCES AND INCOMPATION (PROCESS AND PROCESS AND	BRIAN CEN	ITER HEALTH & REHA	B/HE		THE PROPERTY OF AN OF CORE	RECTION	(X5)
## S329 S35D 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 staff interviews and record reviews, the facility failed to monitor 1 (Resident #22) of 8 sampled residents requiring monitoring for abnormal involuntary movements. Findings include: Findings include:	(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES	PREFIX	(EACH CORRECTIVE ACTION S		
- t use a facility policy and procedure,	F 329	483.25(i) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse conseque should be reduced combinations of the Based on a compresident, the facility who have not use given these drugs therapy is necess as diagnosed and record; and residdrugs receive grabehavioral intervecontraindicated, drugs. This REQUIREM by: Based on staff facility failed to sampled reside abnormal involutions included.	GIMEN IS FREE FROM RUGS g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any e reasons above. The ensive assessment of a try must ensure that residents durities antipsychotic drug ary to treat a specific condition of documented in the clinical ents who use antipsychotic drug ary to treat a specific condition of the discontinue dural dose reductions, and entions, unless clinically in an effort to discontinue these MENT is not met as evidenced interviews and record reviews, the monitor 1 (Resident #22) of 8 ints requiring monitoring for untary movements.	F 329	"Preparation and for executation correction does not constitute adagreement by the provider of the alleged or conclusions set forthin deficiencies. The plan of correct and/or executed solely because it provisions of federal and state is accomplished for the adeficient practice in recompleted 9/18/12 2. Facility resident who prescribed antipsyche medications have the be affected by the sadeficient practice. Resident practice. Resident practice. Resident practice. Resident practice. Resident practice in reports and reviewir for new admissions interdisciplinary Te IDT meeting. A curvill be validated/co	truth of the facts the statement of ion is prepared tis required by the tw." as been alleged gards to esting no are otic potential to me alleged esidents will g Pharmacy ag medications by the am during the rrent AIMS te	
Review of a facility policy and provided and		Poview of a fa	cility policy and procedure,				

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TATEMENT OF DEF ND PLAN OF CORR	ECTION	IDENTIFICATION NUMBER:	A. BUILI			C	1049
		345262	B. WNG	_		09/20/2	2012
NAME OF PROVIDE				1300	ADDRESS, CITY, STATE, ZIP CODE DON JUAN ROAD TFORD, NC 27944		
BRIAN CENTER	R HEALTH & REHA			HER	THE WEED'S DIAN OF CORRECT	TION	(X5) COMPLETION
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und Mo ass mo mo Pa dy as ini mo o o m F Pa dy co o o o o m F Pa dy co o o o o o o o o o o o o o o o o o o	prement Scale (Assessment purposonitor the development disorder arkinsonian types eskinesia". The assessment was to ditation of antipsy onths ongoing. esident #22 was reliable and fithe physician and fither physician and fith	Abnormal Involuntary IMS) ", revealed the e was documented as "To oment of involuntary is from drug-induced of symptoms to tardive of form indicated the have been completed at the chotic drugs use and every 6 admitted to the facility on nosis to include Alzheimer's behavior disturbance. Review admission orders revealed an (antipsychotic medication) 200 extended Release) at bedtime. Ident's September 2012 rs revealed the resident ive Seroquel 200 mg at bedtime. Ity form entitled "Psychoactive ation" dated 7/2/12, revealed the use of Seroquel was a behavior disorder. Adverse did. "none present". Record no AIMS assessment in the did. An AIMS assessment for as not available during the survey. Itew with the Staff Development 19/18/12 at 5:03 PM, the nurse illity completed AIMS r residents who received edications. The SDC located the cupboard at the nurse desk ole to all nurses.	F	329	3. Systemic Measures purplace to assure that the sa alleged deficient practice recur include: Re-educati Licensed Staff by the Din Nursing beginning on 10 continuing until complet focus on addressing the requirement of the AIMS assessment with the use Antipsychotic Drugs/Re AIMS tesing assessment included in the admission for completion by Licenthe Resident is receiving Antipsychotic Medicati Director of Nursing/des review new admissions testing in the interdiscip meeting daily Monday for need of AIMS testing months Weekend admibe reviewed on Monda Director of Nursing or will audit 3 resident peweeks, than 3 resident months for residents reantipsychotic medicati to ensure a current AII the medical record.	does not on of rector of -11 and e will Sof glan. The will be on packet used staff if gan on. The ignee will for AIMS olinary team thru Friday ng x 3 ssions will ys. The designee or week x 4 monthly x 2 eceiving ons/ Reglan	

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STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		00,,,,, 22.12	\
WD PLAN OF C	0,1112	0.45003	B. WNG		09/20	12012
	VIDER OR SUPPLIER	345262 R/HE	1	REET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG		FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OUTD BE	(X5) COMPLETION DATE
TAG	Continued From page An interview with the Director at 5:06 PM AIMS assessments 's admission, when was started, and the During an interview (DON), on 9/20/12 she expected to se completed on administration antipsychotic medication error rate and the medication error rate and the property of the facility must emedication error rate and the property of the facility must emedication error rate and the property of the facility must emedicate on observing the property of the prope	ge 16 e Resident Care Management on 9/18/12, revealed the were completed on a resident any antipsychotic medication en quarterly. with the Director of Nursing at 6:02 PM, the DON reported e an AIMS assessment be desion for residents on cations E OF MEDICATION ERROR	F 329	4. The Director of Nursing review the audits analyze and report patterns and tree the Quality Assessment at Assurance Committee months and the committee will evaluate effectiveness of the plan outcomes. Additional interventions will be developed the committee and implessore continued complications.	g will the data ends to nd onthly x 3. late the based on eloped by mented to ance on of this plan of admission or he truth of the fa in the statement ection is prepared it is required by	cts of
	(Resident #99, # The findings incl 1. Resident #99	28 and #47).				
:	Review of the ac	dmission physician ' s orders, revealed an order to give (milligrams) subq (subcutaneous)		Facility ID: 943003	If continuatio	n sheet Page 17

		MEDICAID SERVICES	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL			C	
AND LESS OF			B. WN	G		09/20/	2012
		345262			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PRO	OVIDER OR SUPPLIER			1300 E	DON JUAN ROAD		
BRIAN CE	NTER HEALTH & REHA	в/не		HERT	TFORD, NC 27944		(V6)
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F 332	Per the manufacture an anticoagulant giv developing deep verbed rest. 09/19/12 at 8:45 AM medication adminis Nurse #2 was obse (Medication Adminimedication for Resi the resident 's room medication. After the about her injection medication had been block of dates ider Lovenox and a not for Lovenox to be 09/19/12 11:50 AM was reviewed with when she had loo stop date and thord discontinued. An interview, on Conducted with D stated she would have given the morder and written	er's information, Lovenox is en to reduce the risk of in blood clots in patients on M, an observation of a tration pass was made. rved to review the MAR stration Record), prepare ident #99, and proceeded into in to administer the he medication had been taken a resident asked the nurse and Nurse #2 relayed the en discontinued. Itember 2012 MAR revealed a stiffied for the administration of the on the MAR for the stop date after the last dose on 09/20/12. M the MAR for Resident #99 I Nurse #2 and she indicated ked at the MAR, she saw the uight the medication had been 199/20/12 7:20 PM, was irrector of Nursing (DON). She have expected the nurse to edication per the physician's on the MAR.	F	332	1. Corrective action has be accomplished for the alleged deficient practice in regar Resident # 99 a medication Variance was completed, and family notified, new received to give Lovenox resume current medication schedule. Resident # 28 Medication Variance was completed. Physician and Responsible Party notified new orders received, Resident worders received, Resident worders received, Resident worders received, Resident worders received, Resident variance contained and Physician and Responsible Party notified. No new of continue current schedules. Pacification variance current schedules. Pacification variance continue current schedules. Pacification variance current schedules. Pacifi	ds to Physician order and to and to on s d ed and no sident # 47 npleted onsible orders le. e the by the same ce. The d Staff ator and sultant bega is on 9/20 es and will been dated tool for	n
	2. Resident #28 v 06/20/12 with mu Heartburn.	was admitted to the facility on ultiple diagnoses including			competency skills wit Administration.	h medicatio	n

CENTERS	FOR MEDICARE &	MEDICAID SERVICES	(X2) MU	LTIPLE C	ONSTRUCTION	(X3) DATE SURVI	EY
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL			С	
, , , , , , , , , , , , , , , , , , , ,		0.45000	B. WING	·		09/20/	2012
BRIAN CE		TATEMENT OF DEFICIENCIES	ID PREF	1300 HER	ADDRESS, CITY, STATE, ZIP CODE DON JUAN ROAD TFORD, NC 27944 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVI)£10 D⊏ [(X6) COMPLETION DATE
F 332	Continued From page A review of the admrevealed an order the (by mouth) after med A review of the resistadministration recorrevealed instruction 125mg Tablet, chestrength 125mg tamouth (PO) TID (the A review of the resistency of	ission orders dated 06/20/12 nat read: "Gas-x 2 tabs PO nals qd (every day)." dent's medication rd (MAR) for September 2012, ns that read: "simethicone wable (Gas Relief Extra blet, Chewable) 2 tablets by nree times a day)." ident's medication ord (MAR) for September 2012, ns that read: "simethicone ewable (Gas Relief Extra ablet, Chewable) 2 tablets by hree times a day)." of medication pass on 09/19/12 a #1 was observed to administer e tablets to the resident. ient in tums is calcium used to treat acid indigestion as a dietary supplement. The in gas-x is simethicone that ation of trapped gas bubbles ody to get rid of the gas naturally. n 09/19/12 at 8:40 AM, the nacy's Nurse Consultant stated ium carbonate and not I that the nurse made a	F	332	3. Systemic Measures put place to assure that the sar alleged deficient practice of recur include: Directed instruction North Carolina Board of Petrocensed Staff on Docume and Medication errors on Licensed Staff will not be to work until they have rethe training after 11/02/12 addition Licensed staff to facility training DVD on and part two of the medic management system. Each must pass a posttest and successfully complete Mean Pass audits. The Director Nursing /designee will contain the process of Nursing review the audits analyzed and report patterns and the Quality Assessment at Assurance Committee means and the Committee will evaluate frectiveness of the plan outcomes. Additional interventions will be devented the committee and implemassure continued compliance.	does not servicing Jursing in entation 11/02/12. allowed ceived 2. In view the part one ation in Nurse edication or of onduct 2 per er month is the data ends to and onthly x 3. ate the based on eloped by mented to ince.	11/3/1

TEMENT OF	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		PLE CONSTRUCTION	COMPLE	C C
PLAN OF C	CORRECTION	DERTIFICATION	1			09/	20/2012
		345262	- B. VIII (REET ADDRESS, CITY, STATE, ZIP CODE		
AME OF PRO	OVIDER OR SUPPLIER			1 1	1300 DON JUAN ROAD		
BRIAN CE	NTER HEALTH & REHA	AB/HE		<u> </u>	HERTFORD, NC 27944 PROVIDER'S PLAN OF CO	ORRECTION	(X5) COMPLETION
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F 332			F	33	2		
	09/20/12 at 10:31 A that the nurses give and as written on the						
	03/04/08 and had r Prostate Cancer.	as admitted to the facility on multiple diagnoses including					
	2012 revealed an (extended release other day.	cian ' s orders for September order for flomax 0.4mg ER), 1 capsule by mouth every					
	(MAR) for Septem to administer flom other day and gav medication 30 mi other day at 6:30						
	Edition under Do once daily appro same meal."	iatric Dosage Handbook, 11th sage for flomax read: " 0.4mg ximately 30 minutes after the					
	during a medica ER (extended re Resident #47. F the treatment of	5:06 PM, Nurse #1 was observed tion pass to administer Flomax elease) 0.4mg 1 capsule to flomax is a medication used for f an enlarged prostate.					
	Coordinator sta usually served	5:15 PM the Staff Development ted that the evening meal was around 5:30 PM.					
	Observations of	of the unit where the resident				1f configur	ation sheet Page 2

	CORRECTION	IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION	COMPLETE	
		345262	B. WI	IG		naisi)/2012
	ROVIDER OR SUPPLIER	<u> </u>		13	EET ADDRESS, CITY, STATE, ZIP CODE 300 DON JUAN ROAD ERTFORD, NC 27944	j 0 <i>912</i> 0	<i>312012</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE
F 333 SS=D	resided revealed that meal had not yet been A telephone interview pharmacist from the comparation of the pharmacy on 09/20/1 stated that the manufacturer to administer flows ame meal each day medication on an emiside effects of the mean of the Director of Nursi 09/20/12 at 10:31 AM that the nurses give the and written on the M/483.25(m)(2) RESIDISIGNIFICANT MED INTERPOLATION OF The facility must ensure any significant medication administer an anticoa for 1 (Resident #99) of Findings include: Per the manufacturer an anticoagulant give developing deep veir bedrest.	at 5:30 PM, the evening in served. was conducted with a facility 's consulting 2 at 9:03 AM. Pharmacist #1 facturer 's specifications omax 30 minutes after the because giving the pty stomach could increase edication. In stated in an interview on that it is her expectation he medications as ordered AR. ENTS FREE OF ERRORS Lire that residents are free of ation errors. The is not met as evidenced on, record review and staff of failed to prevent a in error by omitting to agulant medication ordered		333	F 333 "Preparation and /or executation of this correction does not constitute admission agreement by the provider of the truth alleged or conclusions set forthin the sta deficiencies. The plan of correction is p and/or executed solely because it is requiprovisions of federal and state law." 1. Corrective action has bee accomplished for the alleged deficient practice in regards Resident # 99 Medication V completed. Physician and Responsible Party notified. Order received to give dose n and resume current orders.	of the facts attement of orepared aired by the to variance	
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NIEKOT	OR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1	CONSTRUCTION	(X3) DATE SURVE COMPLETED	ļ
EMENT OF CO	EFICIENCIES RRECTION	IDENTIFICATION NUMBER:	A. BUILDING		С	\ \
	,		B. WING		09/20/2	2012
		345262	STREE	T ADDRESS, CITY, STATE, ZIP CODE		ļ
ME OF PROV	IDER OR SUPPLIER		130	0 DON JUAN ROAD		ļ
RIAN CENT	ER HEALTH & REHA	B/HE	HE	RTFORD, NC 27944 PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD DE	DATE
F 333	Continued From page 09/11/12 with cumu open repair (of) bilar Review of the admired Resident #99, date to give Lovenox 30 (subcutaneous) bid Further review of the Resident #99 was on bed rest for six 09/19/12 at 8:45 A medication admining Nurse #2 was obsected (Medication Admired Resident 's round in the resident 's round in the resident of the resident, the about her injection medication had be after the last of the page 19/19/12 at 11:5 with Nurse #2 at looked at the Mark of the mode on the MAR of the mode on the MAR of the mode on the MAR of the mode on the mode on the mark of the mode on the mode on the mark of the mode on the mode on the mark of the mode on the mode on the mode on the mode on the mark of the mode on the mode on the mode on the mode on the mark of the mode on the mode on the mode on the mark of the mode on the mark of the mode of the mod	ge 21 lative diagnoses of status post teral quadriceps tendon. ssion physician order for d 09/11/12, revealed an order mg (milligrams) subq (twice a day) for 10 days. he admission orders revealed to be non weight bearing and	F 333	2. Facility residents recanticoagulant therapy here potential to be affected alleged deficient practices residents were reviewed determine anticoagular residents Medication administration records audited by the director for the accuracy of the include a stop date if it and/or omitted doses. 3. Systemic Measures place to assure that the alleged deficient practice by the North Carolina Nursing to come to the train Licensed Staff of Documentation and Merrors on 11/02/12. A licensed staff will not to work until they had this training. In add Licensed staff will we train in DVD on pathwo of the medication system. Each Nurse posttest and success Medication Pass au of Nursing/designer resident on anticoagassure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure there have be seen to success the same assure the s	by the same ce. Facility d to at use, these have been of nursing order to adicated put into e same tice does not ed inservicing a Board of ae facility and on Medication after 11/2/12 ot be allowed ave received ition the riew the facility art one and part on management must pass a afully complete dits. Director e will audit 2 gulation to een no omitted	
Į		Frent ID	:9YEP11	doses daily x 2 week resident per week	eks, than 2	
	S-2567(02-99) Previous Ver	sions Obsolete		madent ner week y	z weeks man.	۷

CENTERS	OR MEDICARE & MEDICAID SERVICES EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
STATEMENT OF AND PLAN OF C	ORRECTION	IDENTIFICATION NUMBER:	A. BUILI			C	2049
		345262	B. WN			09/20/2	2012
	WIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE O DON JUAN ROAD		
		DILLE			RTFORD, NC 27944		
BRIAN CEN	ITER HEALTH & REHA		,		THE RUNDER OF AN OF CORRECT	TION	(X5) COMPLETION
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	DED OF 1	DATE
F 356 SS=C	a daily basis: o Facility name. o The current date. o The total number by the following cal unlicensed nursing resident care per s - Registered nu - Licensed prav vocational nurses - Certified nurs o Resident census The facility must p specified above o of each shift. Dat o Clear and reada o In a prominent residents and vis The facility must, make nurse staff for review at a co standard.	and the actual hours worked tegories of licensed and staff directly responsible for hift: urses. ctical nurses or licensed (as defined under State law). se aides. s. cost the nurse staffing data in a daily basis at the beginning a must be posted as follows: able format. blace readily accessible to itors. upon oral or written request, ing data available to the public ost not to exceed the community	F	356	4. The Director of Nursing review the audits analyzed and report patterns and to the Quality Assessment at Assurance Committee of the committee will evaluate effectiveness of the plan outcomes. Additional interventions will be devented the committee and impleassure continued complished for correction does not constitute and agreement by the provider of the alleged or conclusions set forthis deficiencies. The plan of correct and/or executed solely because provisions of federal and state in the complished for the alleged for the alleged for conclusions of federal and state in the complished for the alleged for the al	e the data rends to and onthly x 3 uate the based on veloped by emented to iance in the statement of this prepared it is required by the statement of the state	
	staffing data for required by Stat This REQUIRED by:	cility must maintain the posted daily nurse g data for a minimum of 18 months, or as ed by State law, whichever is greater. REQUIREMENT is not met as evidenced d on observation, record review and staff			2. Facility resident who potential to be affected alleged deficient praction identified no residents	to have the I by the same ice will be	е
	intervious the f	acility failed to maintain 18 months s. The findings include:			Facility ID: 943003	If continuation	cheet Page 2

CENTERS	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE (CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞΥ
TATEMENT OF ND PLAN OF C	DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUIL	DING		C	
(D) Battor o		0.45063	B. WN	G_ <u>-</u>		09/20/	2012
	VIDER OR SUPPLIER	345262 \B/HE		1300	T ADDRESS, CITY, STATE, ZIP CODE DON JUAN ROAD RTFORD, NC 27944 PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	SUMMARY S	TATEMÈNT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREI TAG	IX	(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	COMPLETION DATE
	(09/08/12 through 0 requested from the the 7AM shift for 09/1 facility was unable staff postings. The Director of Nu interview on 09/20 clerk posted the st drawer at the nurs that she was not a required to mainta 483.60(c) DRUG IRREGULAR, AC The drug regimer reviewed at least pharmacist. The pharmacist of the attending phy nursing, and these	AM the last 2 weeks 19/20/12) of staff postings was facility. The staff postings for 10/10/12 and 09/14/12 and all 7-20/12 were provided. The to provide the remainder of the resing (DON) stated in an 1/12 at 7:50 PM that the ward aff postings and filed them in a re's station. The DON stated ware that the facility was ain 18 months of staff postings. REGIMEN REVIEW, REPORT TON a of each resident must be once a month by a licensed must report any irregularities to ysician, and the director of se reports must be acted upon.		F 428	3. Systemic Measures put to assure that the same all deficient practice does no include; The Director of I trained the Medical Reco on the requirement for ponurse staffing data. Med Record Clerk will keep the inher office for 18 mont Director of Nursing/desi conduct an audit weekly that all the prior 7 days accounted for and filed medical records office. 4. The Director of Nursing review the audits analyzer and report patterns and the Quality Assessment and Assurance Committee mand the Committee will evaluate the committee will evaluate the committee and impleassure continued compliance committee and impleassure continued compliance.	t recur Nursing rds Clerk osting the ical he posting hs. The gnee will to ensure are in the X 3 months e the data ends to and onthly x 3. uate the based on veloped by emented to	11/3/12
	by: Based on staff pharmacist inte facility failed to reported the ne	MENT is not met as evidenced interviews and consultant rview and record reviews, the ensure the consultant pharmacist sed for an abnormal involuntary essment for 1 (Resident #22) of 8 ents receiving antipsychotic					n sheet Page 24 o

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUIL		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345262	B. WIN	s		09/20)/2012
· - · - · - · · ·	OVIDER OR SUPPLIER	В/НЕ	1	13	EET ADDRESS, CITY, STATE, ZIP CODE 00 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT IEACH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPROFICE F 428	LD BE	(X5) COMPLETION DATE
F 428	change and laborator of 1 sampled resident recommendations. Findings include: 1) Review of a facility undated, entitled "A Movement Scale (All assessment purpose monitor the developm movement disorders Parkinsonian types of dyskinesia". The frassessment was to hinitiation of antipsych months ongoing. Resident #90 was ad 7/16/12 with a diagnowith dementia and be of the physician 's accorder for Seroquel (amg (milligrams) (External Review of the resider physician 's orders recontinued to receive Review of a facility for Medication Evaluation diagnosis for the use documented as a befreactions included: "	acility failed to act on dations for a medication by tests for 1 (Resident #90) at with pharmacy by policy and procedure, bnormal Involuntary (MS) ", revealed the was documented as "To nent of involuntary from drug-induced for symptoms to tardive form indicated the ave been completed at the otic drugs use and every 6 (mitted to the facility on the position orders revealed an intipsychotic medication) 200 anded Release) at bedtime. In the serious and the serious drugs are to serious drugs as a serious drugs and the resident seroquel 200 mg at bedtime. The mentitled "Psychoactive of Seroquel was navior disorder. Adverse none present". Record	F	428	"Preparation and /or executation of the correction does not constitute admissing agreement by the provider of the truth alleged or conclusions set forthin the signal deficiencies. The plan of correction is and/or executed solely because it is responsible of the alleged of the alleged deficient practice in regard Resident # 22 AIMS testing completed 9/18/12 Resident will transition to the apeut interchange as recommend the Pharmacy Consultant we current supply is exhausted will be drawn at that time. 2. Facility resident who are prescribed medications have potential to be affected by alleged deficient practice. In pharmacy consultant reports be reviewed by the Director Nursing/designee for the precommendations have become designed as appropriate. The Director of Nursing or designal identify Residents who Antipsychotic Medications.	en ed ls to g the facts tratement of prepared quired by the en ed ls to g the facts to g the facts will be the same of the transfer of ast 60 transcy en the facts will be of the transcy en the facts will be of the transcy en the facts of the transcy en the facts will be of the transcy en transce trans	
	resident's record. A	IMS assessment in the In AIMS assessment for It available during the survey.			Antipsychotic Medications reviewing the Pharmacy re	•	

Facility ID: 943003

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345262		B. WN	B. WNG		C 09/20/2012		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/HE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETION	
F 428	formulated a plan for documentation of an an of a pharmacy recommendation of an an of a pharmacy recommend. AlMS assessment for During a telephone in Pharmacist #2 on 9/2 Pharmacist stated the completing the AlMS months for residents medications. The Pharmacist stated he recommendations to assessment was required to assessment was required. The Pharmacist Resident #22 stated the recommendations to assessment was required. The Pharmacist Resident #22 stated the recall Resident #22 stated the recall Resident #22 stated the recall Resident #20 was 7/16/12 with a diagnothypercholesteremia (conclusive of a pharmacist 8/20/12 revealed a result when the current substantial explanation (medication) and of the pharmacist stated in the pharmacist stated here as a second resident pharmacist pharmacist stated here as a second resident pharmacist pharmacist p	ed the resident was macist on 7/24/12 and the resident with no AIMS assessment. Review mendation of 8/20/12 endation for the need of an the resident. terview with the facility 0/12 at 6/45 PM, the facility standard for assessments was every 3 receiving antipsychotic armacist stated during his ould also review the AIMS gup to date. The would have made the facility when an AIMS sired if one had not bee macist was not able to be cifically. admitted to the facility on sis to include elevated cholesterol). y recommendation, in part, as apply of Simvastatin is naider changing to ion to lower high levels of facting lipid panel."	F	428	Residents identified will have current AIMS test validated/completed. New admissions will be reviewed antipsychotic use by the Interdisciplinary Team in the morning meeting. Residents identified as being prescribe antipsychotic medication with a current AIMS validated/completed.	l for e s ed an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		С			
		345262	B. WING		09/20/2012			
		в/не	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944					
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL)			D BE	(X5) COMPLETION DATE		
F 428	ENTER HEALTH & REHAB/HE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 Simvastatin (medication to lower high levels of cholesterol) 40 mg (milligrams) every night. Review of the resident 's September 2012 physician 's orders revealed the resident continued to receive Simvastatin 40 mg every night. Review of subsequent orders revealed no orders for changes in the medication. A telephone call to the physician's office by the Staff Development Coordinator on 9/20/12 at 2:43 PM and subsequent interview with the SDC revealed the physician 's office did not receive any pharmacy recommendation requests for lab tests. During interview with the Director of Nursing (DON) on 9/20/12 at 4:24 PM, the DON stated she was responsible for the pharmacy recommendations and not yet sent out the recommendations of 8/20/12. The DON stated she was late sending the recommendations to the physician 's office for approval.		F 428	1300 DON JUAN ROAD HERTFORD, NC 27944 ID PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) 3. Measures put into place				

7-428 4. Director of nursing will review the audits analyze the data and report patterns and trends to the Quality Assurance Committee monthly x 3. The quality assurance committee will evaluate the effectiveness of the above plan monthly and will add additional interventions based on negative outcomes to assure continued compliance.

11/3/12

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TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED V & & 2012		
		345262	B, WI	√G_		1	2/2012	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/HE				STREET ADDRESS, CITY, STATE ZIP CODE 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)		PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLÉTIC		
K 029 SS≃D	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 LIFE SAFETY CODE STANDARD		K		"Preparation and for executation of this correction does not constitute admission agreement by the provider of the truth of alleged or conclusions set forthin the state deficiencies. The plan of correction is provided and state law." 1. Corrective action has been accounted to the door on the soiled line laundry the closure was adjusted to the door to close and latch appropriately. Audit was comediated appropriately. Audit was comediated appropriately. Audit was comediated appropriately. Audit was comediated appropriately. 3. Systemic measures to prevent reoccurrence will be for the Mainter Director to complete monthly audited doors in hazardous locations. Negating swill be corrected immediat Results of audits will be reported to safety committee monthly x3 then on a quarterly basis. 4. The Maintenance Director will results to the Quality Assessment and Assurance Committee monthly x 3 Quality Assessment and Assurance Assurance Committee will evaluate effectiveness of the plan based on tidentified and develop and implement additional interventions as needed to the content of the plan based on tidentified and develop and implement additional interventions as needed to the plan based on tidentified and develop and implement additional interventions as needed to the plan based on tidentified and develop and implement additional interventions as needed to the plan based on the p	or f the facts tement of epared ired by the implished en side of allow iately s areas e and impleted ireas close mance s of tive ely. The implication going eport ind impleted ireas close eport ind impleted ireas close eport ind impleted ireas eport irea		
And					continued compliance.		11/16/12	
BODATOD	NECTOR'S OF PROVID	EDISTIDDI IED DEDDESENTATIVES SIGN	ATUDE		JITI E		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 tays 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.

ORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 9YEP21

Welsher RN. LNHA

Facility ID: 943003