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

JAN 2 9 2013 actual date forced accepted 1/22/13

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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
	345323	A. BUILDING _____ B. WING _____	C 12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHABILITATIO	647 S RAILROAD ST BOX 966 WALLACE, NC 28466

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the MAR (medication administration record) was kept covered to maintain resident privacy for 2 of 10 residents (#7 and #49. The findings include:	F 164	Angela Leonard, RN, and Director of Nursing immediately provided RN #1 re- education on 12-13-12.regarding HIPPA guidelines to include privacy practice. The facility Director of Nursing completed facility audit observations to ensure that each facility licensed nurse was compliant with HIPPA guidelines to include privacy of medication and treatment record. The facility licensed nursing staff received re- education regarding HIPPA guidelines to include privacy practice regarding covering of medication and treatment records on 12-13-12 by Staff Development Coordinator. The facility newly hired licensed nurses will receive education during the new hire orientation regarding HIPPA guidelines.	12/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Stilwell — TITLE: Administrator — (X6) DATE: 1/8/13

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.

S.W.

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F 164	Continued From page 1 1. Resident #7 was admitted to the facility on 12/08/09 with cumulative diagnosis that included Diabetes Mellitus, Congestive Heart Failure and Atrial Fibrillation. An observation of the medication cart was made on 12/11/12 at 10:30 AM. The nurse was not at the cart and the MAR was opened to a page for resident #7. After 5 minutes, Nurse #1 came back to the cart. She began to sign entries on the MAR. When asked, Nurse #1 stated " I have not been told anything specific regarding covering the MAR. " When asked if she had had any training about this she stated " no. " During an interview with the Director of Nursing (DON) on 12/13/12 at 11:15 AM it was revealed " I expect that the MAR always be covered if the nurse is not at the cart. We do go over HIPPA training during orientation. " 2. Resident #49 was admitted to the facility on 11/05/12 with cumulative diagnosis that included History of Stroke, and Diabetes. During a medication administration observation on 12/11/12 at 3:55 PM, Nurse #1 was observed to prepare the medications at the cart and then to walk into resident #49 ' s room to administer the medications. Nurse #1 did not cover the MAR. Nurse #1 left the resident ' s room and walked to the desk to check an order. The MAR was still not covered. Nurse #1 came back to the cart and prepared another medication and brought it into the resident #49 ' s room. Again the MAR was left uncovered on the cart. When asked about the MAR being left uncovered, Nurse #1 said "	F 164	The facility staff to include contracted employees were provided re-education on the privacy rules and HIPPA guidelines on 12-13-12 by Staff Development Coordinator and Health Information Clerk and completed on 1-10-13. The facility newly hired staff will receive education during the new hire orientation regarding HIPPA guidelines by facility Staff Development Coordinator. The facility Director of Nursing will complete 1 – 2 random sample observation of licensed nurses to ensure that HIPPA guidelines are in place related to covering of medication records and/or treatment Monday – Friday times four weeks alternating shifts. The facility Director of Nursing will report results of observation to QAPI committee monthly x 2. The QAPI committee will review and analyze for trends.	1/10/13

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F 164	Continued From page 2 Oh I forgot. " During an interview with the Director of Nursing (DON) on 12/13/12 at 11:15 AM it was revealed " I expect that the MAR always be covered if the nurse is not at the cart. We do go over HIPPA training during orientation. "	F 164		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interviews, the facility failed to ensure that the pull cords for the overbed lights were long enough for the resident to reach for 2 of 18 rooms (room 208) and failed to ensure that the overbed light was functioning for 1 of the residents in room 208 (resident #7). The findings include: An observation on 12/10/12 at 6:00PM revealed that the pull cords for the overbed lights for both bed 1 and bed 2 in room 208 were not reachable by the residents in the beds. The cord for bed #1 was about 4 inches long and the cord for bed #2 was about 2 inches long. An observation on 12/11/12 at 3:55 PM revealed that the pull cords for both bed 1 and bed 2 in room 208 were not reachable by the residents in the beds. The cord for bed #1 was about 4 inches long and the cord for bed #2 was about 2 inches long. During this observation the resident	F 253	The facility Maintenance Director replaced the light cord in 208 beds 1 and 2. The Maintenance Director ensured that 208 bed 1and 2 could reach by having the residents complete a return demonstration. The Facility Maintenance Director Repaired Resident #7 light by adjusting the bulb. The facility Maintenance Director completed facility review of each resident room to ensure that each resident light was in working condition and that each resident over bed light had a reachable pull cord on 12-14-12. The Maintenance Director will complete room observations at least once a month to ensure that resident lights are properly functioning and each over bed light has reachable light cord.	

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F 253	Continued From page 3 in bed #2 (resident #49) asked the nurse to turn on the light for her because she was using a lap top computer. During an interview with resident #49 at this time it was revealed " It is important to me to be able to use the light when I want so that I can use my computer. " An observation on 12/13/12 at 9:30 AM revealed that there had been no change in the condition of the pull cords. In addition, at this time the resident in bed #1 (resident# 7) indicated that her light did not work. During an interview with resident #7 at this time it was revealed " my light has not worked in a long time. I have told the girls. " During an interview with the Maintenance Director on 12/13/12 at 10:30 AM it was revealed " there is a clipboard that staff can write on to indicate the things that need to be fixed. I check it every day. The clip board is kept at the nursing station. I also make rounds into all the rooms at least every 45 days. " The Maintenance Director went to his office to get the clipboard. Observation of the clip board revealed entries from August 12, 2012 to the present. There was no indication on it of any documentation related to the need for work in room 208. The Maintenance Director stated that he " was not aware of the need for longer cords or that the light in the room for bed 1 was not working. " During an interview with the Administrator on 12/13/12 at 12:08 PM it was revealed " we have an Ambassador program (staff assigned to check on resident ' s and their rooms daily). This usually includes is the room clean, do the call bells work and does the resident have any	F 253	Facility resident ambassador will complete 1-2 sampled room observation weekly times four. The facility will communicate any concerns related to lights/ or light cords to the facility Maintenance Director by using the maintenance clipboard. The facility staff were provided re- education regarding process when a maintenance issue identified to include lights and/or light cords given by the Staff Development Coordinator and Health Information Coordinator started 12/13/12 and completed on 1/10/13. The facility Maintenance Director will report results of room observation to Quality Assurance committee (QAPI) monthly x 2. The QAPI committee will review and analyze for trends.	1-10-13

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F 253	Continued From page 4 concerns. I never thought about checking the strings to be sure that the resident could reach it. I would expect that if staff noticed that the cord was to short that they should report it. "	F 253		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	The Facility Director of Nursing completed observation audit of facility areas where medication was stored to ensure that no medication were stored with expiration dates on 12-13-12 or before. The facility Director of Nursing and/or Assistant Director of Nursing will complete weekly audits of medication room times four weeks to ensure medications are not stored out of date. Facility licensed nurses were provided re- education regarding the process of checking medication prior to administration for expiration dates on 1-04-13 by facility Staff Development Coordinator and completed on 1-10-13. The facility newly hired licensed nurses will review education regarding medication stored to include checking for expiration dates during new hire orientation.	1/10/13

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F 431	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews, the facility failed to ensure that there were no expired items in one of one medication storage rooms. Findings include: On 12/12/2012 at 4:00 PM, in the only medication storage room in the facility, there were six boxes of glucose control solution (used to test the accuracy of a glucometer, which is used to test blood sugar), dated 2012-10 (October,2012).Each box contains two 4 ml bottles, one marked hi and one marked lo. Each bottle has an expiration date of 2012-10 (October,2012). There were three bottles of Banophen oral solution (an antihistamine for allergy relief or common cold), two with an expiration date of 09/12 (September, 2012), and one with an expiration date of 07/12 (July,2012). On 12/12/2012 at 4:40 PM, in an interview, the Assistant Director of Nursing (ADON) stated that the transportation aide also stocks the med storage room. The ADON also stated that this same aide is responsible for inventory. On 12/12/2012 at 4:55 PM, the Director of DON Nursing (DON) stated, in an interview, that the Pharmacy comes every four to six weeks, but mainly checks the carts, although the Pharmacy sometimes rotates the stock. The DON also stated that all meds are checked for expiration when they are brought out of the medication storage room.	F 431	The facility Director of Nursing will report results of observation to QAPI committee monthly for two months. The QAPI committee will review and analyze for trends.	

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F 431	Continued From page 6	F 431		

In an interview on 12/13/2012 at 1:45 PM, the aide who is in charge of the medication storage room supply and inventory, stated that she does an inventory every week which consists of rotating the stock and checking expiration dates. The aide stated that if stock is expired, she puts it in the bin to go back to the pharmacy.

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	345323	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHABILITATIO	647 S RAILROAD ST BOX 966 WALLACE, NC 28466

FEB 11 2013

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 1/24/2013 the following Life Safety item was observed as noncompliant, specific findings include: The post indicator valve (PIV) just outside the sprinkler riser room failed to give a supervisory signal at the fire alarm control panel when tested. NOTE: This deficiency was corrected by the facilities contractor before the end of the life safety survey. CFR#: 42 CFR 483.70 (a)	K 062	The alleged deficiency noted as "post indicator valve failed to give a supervisory signal at the fire alarm control panel" was corrected before end of survey. The Maintenance Director will do a weekly test of the supervisory system with a minimal turn of the valve sufficient to initiate trouble signal for the next four weeks, and then monthly thereafter during regular fire drills for the next three months. Any negative results will be reported immediately to the Administrator and any repairs done immediately. All results will be reported to and discussed during the next three monthly Safety Committee meetings and continue with quarterly reports thereafter until next annual survey. Correction date of 1/24.	1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Steinwalt | TITLE: NHA | (X6) DATE: 2/5/13

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