STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 01/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND RETIREMENT	752 E CENTER AVE MOORESVILLE, NC 28115

(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 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to obtain permission from a resident's responsible party to administer a new medication as requested for 1 of 3 sampled residents (Resident #2). The findings are: Resident #2 was admitted to the facility on 12/10/12 with diagnoses that included Alzheimer's disease and others. The initial Minimum Data Set (MDS) dated 12/17/12 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. Resident #2's medical record was reviewed and revealed a hospital History and Physical dated 10/02/12 that specified the resident was allergic to iodine and codeine and specified the family preferred to avoid all pain medicines due to past	F 152	F 152 1. Corrective action cannot be accomplished for the alleged deficient practice in regards to Resident #2 as the resident has been discharged. 2. Facility residents who have guardians or other legal surrogates have the potential to be affected by this same alleged deficient practice; therefore, the Director of Social Services will complete an audit of current residents to identify those with guardians and/or legal surrogates. Any negative finding will be immediately corrected. This audit will be completed on or before 2-14-13. 3. Measures put into place to ensure that the alleged deficient practices does not recur include: In-service for facility license nursing staff and department managers regarding the rights of a guardian or legal surrogate, how to identify a guardian or legal surrogate and care requests of the guardian or legal surrogate by the Administrator "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 provisions of Federal and State law."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S. Administrator 2.14.13

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.

DHSR NCH Black Mountain WRO Received FEB 25 2013 by: SKH

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F 152	Continued From page 1 adverse reactions. A document titled "Consent to Treatment" dated 12/10/12 specified the resident's responsible party (RP) notified the facility that she was to be contacted before any medication changes were made for Resident #2. The document had a hand written note made by the RP that listed her contact information. In addition, a document titled "Nursing Admission Assessment" dated 12/10/12 specified Resident #2' s RP did not want any new medication given without being notified first. The document included the RP's name and contact information. Further review of Resident #2's medical record revealed a nurses' entry made by Nurse #1 dated 12/25/12 at 3:54 AM that specified the on-call physician was notified for the resident's increased agitation and Tylenol was ordered. The Medication Administration Record (MAR) for 12/25/12 was reviewed and revealed the resident received 2 doses of Tylenol. A later nurses' entry dated 12/25/12 at 5:00 PM specified Resident #2's RP was present and identified that Resident #2 was lethargic. The RP was notified that Resident #2 had been given Tylenol. The entry specified Resident #2's RP was not made aware of the new order for Tylenol and the RP notified the facility that Resident #2 did not tolerate Tylenol. The RP requested for the resident to be sent to the Emergency Department for evaluation. A "Resident Transfer Form" dated 12/25/12 specified Resident #2 was transferred to the Emergency Department due to a change in mental status. Resident #2 was admitted to the hospital on 12/25/12 and diagnosed with altered mental status secondary to a urinary tract infection (UTI).	F 152	and or Director of Nursing. The Director of Nursing, Unit Manager/ Coordinator and or Staff Development Coordinator will monitor Physician telephone orders daily, Monday thru Friday for a period of three (3) week and then weekly for a period of four (4) weeks thereafter to ensure guardians or legal surrogates are notified of medication changes. 4. The Director of Nursing and/ or Administrator will analyze the data for trends and patterns. The Director of Nursing and/ or Administrator will report the finding to a QA/PI Committee weekly for a period of four (4) weeks and then monthly. The QA/PI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of Federal and State law."	

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F 152	Continued From page 2 The hospital discharge summary dated 12/31/12 specified, "The resident does have an allergy to Tylenol and was apparently given this at the nursing home which made her more confused." On 01/18/13 at 11:15 AM Nurse #2 was interviewed and reported that she was Resident #2's admitting nurse on 12/10/12. She confirmed that she completed the "Nursing Admission Assessment" for Resident #2 and was notified by the RP that the resident was not to receive any new medications without being notified first. Nurse #2 stated that Resident #2 was unable to communicate or make her needs known and relied on staff to anticipate her needs. Nurse #2 stated she documented the RP's request to be notified before Resident #2's medications were changed on the admission assessment and notified the oncoming nurse during shift report. Nurse #2 stated she did not document the information anywhere else in the medical record. On 01/18/13 at 12:45 PM the Admissions Receptionist was interviewed and reported she recalled completing the "Consent to Treatment" form with Resident #2's RP. She added that the RP stated she did not want changes made to Resident #2's medications without being notified. The Admissions Receptionist stated she notified the Nurse #2 of the RP's request. On 01/18/13 at 11:05 AM the Director of Nursing (DON) was interviewed and stated she would not have expected Nurse #1 to contact Resident #2's RP at 3:45 AM to notify her of a new order to administer Tylenol to Resident #2. The DON added that specific instructions such as family requesting that no new medications be given	F 152	"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 provisions of Federal and State law."	

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F 152	Continued From page 3 without approval from the family should be documented in a central location for all nurses to see it. She added an ideal location would be on the resident's Medication Administration Record (MAR) but that it was not required since the request was not a physician's order. On 01/18/13 at 11:50 AM the Physician was interviewed and reported that when administering new medications and obtaining orders for new medications the facility had to use the best available information for making the best decision for a resident and added that in the case of Resident #2 the best available information regarding the resident would have come from the RP and added the facility should have contacted her before administering Tylenol. On 01/22/12 at 10:15 AM Nurse #1 was interviewed on the telephone and reported that she contacted the on-call physician on 12/25/12 because Resident #2 appeared agitated. She stated she received an order for Tylenol and gave the resident 2 doses of the new medication. Nurse #1 stated she was not aware of the RP's request to be contacted before making changes to the resident's medications. She stated she would not have known to look at the Admission Assessment for the information.	F 152	"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 provisions of Federal and State law."	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #7 in that the Director of Nursing ensured the resident received proper incontinence upon notification. NA #2 was provided immediate training by the Director of Nursing and or the Staff Development Coordinator	

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F 312	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy, and staff interviews facility staff failed to properly provide incontinence care for 1 of 1 resident observed for incontinence care, Resident #7. The findings included: A facility policy entitled Perineal care of the female patient dated 10/06/13 read in part, "Separate her labia with one hand and wash with the other, using gently downward strokes from the fromt to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina. Avoid the area around the anus, and use a clean section of the washcloth for each stroke by folding each use section inward. This method prevents the spread of contaminated secretions or discharge." Resident #7 was admitted to the facility 12/31/12, with diagnoses that included Alzheimer's disease and cerebral vascular accident with left hemiparesis. Review of Resident #7's Admission Minimum Data Set (MDS) revealed she had long and short term memory problems and was impaired for daily decision making. The MDS further assessed Resident #7 as needing extensive to total assistance with activities of daily living. The MDS indicated Resident #7 was frequently incontinent of bowel and bladder. An observation was made on 01/17/13 at 2:20	F 312	regarding the provision of proper incontinence care. 2. Facility residents who are dependant for incontinence care have the potential to be affected by this same alleged deficient practice; therefore, the Director of Nursing and/ or Unit Coordinator/ Manager will complete an audit of current residents to identify those residents who are dependant for incontinence care and review for any potential patterns of UTI's. The Administrator will review the past six (6) months of concerns and Resident Council minutes identifying any issues with incontinence care. Any negative finding will be immediately corrected. This audit will be completed on or before 2-14-13. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service for facility nursing staff by the Director of Nursing and/ or Unit Coordinator/ Manager and/ or Staff Development Coordinator regarding proper incontinence care. CNAs will validate understanding with return "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 provisions of Federal and State law."	

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F 312	Continued From page 5 PM of Nursing Assistant (NA) #2 providing incontinence care for Resident #7. NA #7 had gathered supplies of washcloths, towels and a wash basin. With Resident #7 lying on her back NA #2 cleaned the groin area (the crease between the leg and the groin). She cleaned front to back and then turned the resident on her side to clean her buttocks and anal area. NA #2 did not clean Resident #7's peri-area. After turning Resident #7, NA #2 cleaned her buttock and anal area. Resident #7 had a loose bowel movement, which was noted in the perineal area. NA #2 removed the soiled brief and put on a clean brief under her buttocks. NA #2 then rolled Resident #7 to her back and proceeded to fasten the brief. NA #2 was asked to stop at this point as she had not cleaned Resident #7's peri-area. NA #2 then reached into the wash basin and picked up a wash cloth that was visibly soiled with feces (spot approximately 3 inch in diameter) and proceeded to go toward the resident to clean her peri-area. Again, NA #2 was stopped and asked if she should use the soiled wash cloth to clean the resident's peri-area. She stated no, that she would have to get more clean linen. NA #2 removed her gloves and exited the room. NA #2 returned to the room with clean linen and proceeded to clean Resident #7's peri-area, wiping front to back removing all loose stool in this area. An interview was conducted on 01/17/13 at 2:55 PM with NA #2. NA #2 stated she should have cleaned Resident #7's peri-area thoroughly. NA #2 further stated she should not have used a washcloth soiled with stool to clean the peri-area. She stated she should have used a clean washcloth.	F 312	demonstration of learning to the Director of Nursing, Staff Development Coordinator or a North Carolina Licensed Nurse (RN/LPN). The Director of Nursing, Unit Coordinator/ Manager and or Staff Development Coordinator will conduct incontinence care rounds at least three (3) time per week for a period of four (4) week, and then randomly for a period of three (3) months to validate appropriate incontinence care techniques are being used. Negative finding will be immediately corrected. 4. The Director of Nursing and/ or Administrator will analyze the data for trends and patterns. The Director of Nursing and/ or Administrator will report the finding to a QA/PI Committee weekly for a period of four (4) weeks and then monthly. The QA/PI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of Federal and State law."	

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F 312	Continued From page 6 An interview was conducted 01/17/13 at 4:05 PM with the Staff Development Coordinator (SDC). The SDC stated that when new nursing assistants are hired they are observed performing skills by a nurse or a senior nursing assistant before they are allowed to work independently. He stated incontinence care was one of the skills that should be observed. The SDC stated that nursing assistants are expected to clean the peri-area during incontinence care. He further stated NA #2 should have used a clean washcloth to clean Resident #7's peri-area. An interview was conducted on 01/17/13 at 4:45 PM with the Director of Nursing (DON). The DON stated it was her expectation for staff to thoroughly clean a female resident's peri-area during incontinence care. She further stated NA #2 should have used a clean washcloth when cleaning the peri-area.	F 312	"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 provisions of Federal and State law."	
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 observation, medical record review, and staff interviews the facility failed to put a chair and bed alarm in place for 1 of 3 residents	F 323	F 323 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1 in that upon notification, the Director of Nursing ensured the alarms were in place and operational. Further, the Direction of Nursing provided training to NA #1regarding the placement and operation of safety alarms. 2. Facility residents with safety alarms have the potential to be affected by this same alleged deficient practice;	

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F 323	Continued From page 7 identified as having falls, Resident #1. The findings included: Resident #1 was admitted to the facility 01/09/13 with diagnoses which included right hemiparesis. Review of Resident #1's Admission Minimum Data Set (MDS) dated 01/16/13 revealed she had long and short term memory problems and was impaired for daily decision making. The MDS assessed her as needing extensive assistance with transfers and her balance as being unsteady when moving from a sitting to standing position. Further review of the MDS revealed Resident #1 had a fall prior to admission to the facility and had two falls after she was admitted to the facility. Review of Resident #1's care plan for falls dated 01/10/13 revealed a pressure pad alarm for her chair and her bed were initiated on 01/10/13. The care plan listed dates the resident had fallen as 01/10/13 and 01/12/13. An Interdisciplinary Post Fall Review form dated 01/10/13 revealed Resident #1 had a fall when she stood up from her wheel chair and she attempted to sit back down. The wheel chair the chair rolled out from under her as the breaks were not locked. Further review of this form revealed a pressure pad alarm was added to her chair and her bed. An Interdisciplinary Post Fall Review form dated 01/13/13 revealed Resident #1 had a fall on 01/12/13. Resident #1 was observed on the floor of her room. She stated she had tried to get her gown out of her drawer. This form further	F 323	therefore, the Director of Nursing and/ or Unit Coordinator/ Manager and/ or Staff Development Coordinator will complete an audit of current residents to identify those residents with safety alarms to assure they are in place as deemed necessary. Any negative finding will be immediately corrected. This audit will be completed on or before 2-14-13. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service for facility nursing staff by the Director of Nursing and/ or Administrator regarding the use of safety alarms. An IDT team will conduct a review of identified residents to ensure the most effective safety alarm is in use. The Director of Nursing, Unit Coordinator/ Manager and IDT will make safety rounds daily, Monday thru Friday, for a period of four (4) weeks, then three (3) times weekly and randomly for a period of four (4) weeks, to include the use of safety alarms. Any negative findings will be immediately corrected. "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 provisions of Federal and State law."	

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F 323	Continued From page 8 revealed the resident was educated to call for assistance. A review of the Resident Care Grid used by nursing assistants to know how to care for each resident revealed Resident #1 was to have a pressure pad alarm on her bed. An observation was made on 01/17/13 at 12:30 PM of Resident #1 in her room sitting in her wheel chair. Resident #1 did not have an alarm on her wheel chair. An observation was made on 01/18/13 at 10:33 AM of Resident #1 again sitting in her room in her wheel chair. Resident #1 did not have an alarm on her wheel chair. On 01/18/13 at 11:05 AM an observation was made of Nursing Assistant (NA) #1 transferring Resident #1 from her wheelchair to bed. After finishing the transfer NA #1 then left the room. Resident #1 did not have a bed alarm on her bed. NA #1 did not check to see if the Resident #1's bed alarm was in place. An interview was conducted on 01/18/13 at 11:20 AM with NA #1. He stated Resident #1 did not have an alarm on her wheel chair. He stated there was a pad for an alarm on Resident #1's bed but the cord from the pad was not connected. He stated there was no alarm box on the bed. NA #1 also stated, looking at his Care Grid, that Resident #1 should have a bed alarm. An interview was conducted on 01/18/13 at 11:30 AM with Nurse #1. Nurse #1 stated the box / alarm was missing. She stated there should have	F 323	4. The Director of Nursing and/ or Administrator will analyze the data for trends and patterns. The Director of Nursing and/ or Administrator will report the finding to a QA/PI Committee weekly for a period of four (4) weeks and then monthly. The QA/PI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of Federal and State law."	

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F 323	Continued From page 9 been a pad under the resident ' s cushion in her wheel chair and there should have been a box that the bed alarm was plugged into. An interview was conducted on 01/18/13 at 12:00 PM with the Director of Nursing (DON). She stated it was the Unit Coordinator #1's responsibility to check to make sure the alarm was implemented. The DON further stated the alarm box and pad should have been on the chair and the bed. An interview was conducted on 01/18/13 at 12:20 PM with Unit Coordinator (UC) #1. UC #1 stated it was not his responsibility to initiate the alarm. He stated the alarm should have been initiated on 01/10/13 by someone from the interdisciplinary team. He stated nursing assistants and nurses were to check placement. An interview was conducted on 01/18/13 at 12:26 PM with Unit Coordinator #2. She stated it was everyone's responsibility on the interdisciplinary team to make sure the alarm was put into place. She further stated, "it was not determined who actually was going to put the alarm on, we just assumed someone would." She stated the alarm should have been put on by the nurse who was working with her on the 01/10/13.	F 323	"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 provisions of Federal and State law." F 333 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #2 in that medical intervention and monitoring were completed as directed by the Attending Physician. Medication Aide #1 was provided with immediate training by the Director of Nursing regarding the administration of medications. 2. Facility residents who receive medications have the potential to be affected by this same alleged	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	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 10 Based on interviews and record review the facility gave the wrong medications to 1 of 3 sampled residents (Resident #2). The findings are: Resident #2 was admitted to the facility on 12/10/12 with diagnoses that included Alzheimer's disease and others. The initial Minimum Data Set (MDS) dated 12/17/12 specified the resident had short and long term memory impairment and severely impaired cognitive skills for daily decision making. Review of Resident #2's medical record revealed a nurses' entry dated 01/08/13 that specified the resident's vital signs were being closely monitored due to a "medication error." On 01/17/13 at 12:00 PM the Staff Development Coordinator (SDC) was interviewed and stated that on 01/08/13 Resident #2 was given Resident #8's medications by accident. He stated that the facility recently transitioned to using medication aides to administer residents' medications. He reported that the medication aides were trained to identify residents prior to administering medications by using pictures kept on file on the Medication Administration Record (MAR). He added that if a resident did not have a current picture on the MAR then the medication aide could verify a residents' identity by checking the arm band. He added that on 01/08/13 medication aide #1 did not identify Resident #8 with a picture on the MAR or her arm band and as a result gave the medications to Resident #2. He stated that Resident #2 experienced facial swelling and was ordered Benadryl and close monitoring by the	F 333	deficient practice: therefore, the Director of Nursing and/ or Unit Coordinator/ Manager and/ or Staff Development Coordinator will complete an audit of current residents to identify those residents who need assistance in the administration of their medications. This audit will be completed on or before 2-14-13. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service for facility licensed nursing staff and medication aides by the Director of Nursing and/ or Staff Development Coordinator regarding the proper identifications of resident by use of arm band and/ or photograph prior to the administration of medications with return demonstration. The Director of Nursing, Unit Coordinator/Manager and/ or Staff Development Coordinator will conduct Medication Administration Audits at least three (3) times weekly for a period of 90 days and randomly thereafter to validate appropriate patient identification techniques are being used. Any negative finding will be immediately corrected. "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 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
	345179	A. BUILDING _____ B. WING _____	C 01/18/2013

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F 333	Continued From page 11 physician. On 01/17/13 at 12:15 PM medication aide #1 was interviewed and reported she was new to administering medications. She stated she was trained to verify a residents' identity using pictures of residents on the MAR or by checking a resident's arm band before she administered medications. She stated that on 01/18/13 she entered Resident #8's room to give medications and the resident was not there. She stated she asked Resident #8's nurse aide where the resident was and was told the resident was in the beauty shop. Medication aide #1 added she went to the beauty shop and saw a female resident and asked the beautician if the resident was Resident #8. Medication aide #1 stated she gave the resident in the beauty shop the medications intended for Resident #8. She added she became aware a little time later that she gave Resident #8's medications to Resident #2. The medication aide reported that not all residents had picture identification on the MAR and confirmed that Resident #8 did not have a picture on her MAR. On 01/17/13 at 3:45 PM the Director of Nursing (DON) was interviewed and stated the facility had identified the medication error occurred as result of the medication aide failed to identify who the resident was that she gave medicine to. She stated that Resident #2 did not experience adverse reaction from the medications she received in error. The DON provided documentation of the medications given to Resident #2 that included: - Norvasc (antihypertensive) 10mg (milligrams)	F 333	4. The Director of Nursing and/ or Administrator will analyze the data for trends and patterns. The Director of Nursing and/ or Administrator will report the finding to a QA/PI Committee weekly for a period of four (4) weeks and then monthly. The QA/PI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of Federal and State law."	

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F 333	Continued From page 12 - Abilify (antipsychotic) 5mg - Miralax (laxative) 17 grams - Lisinopril (blood pressure medication) 20mg - Sinemet (anti-Parkinsonism) 25/100mg - PreserVision (multivitamin) 1 tablet - Ditropan (blood pressure medication) 5mg On 01/18/13 at 11:50 AM Resident #2's physician was interviewed and stated he was notified of the medication error and ordered Benadryl for the allergic reaction of facial swelling and close monitoring of the resident's vital signs. He stated that he was concerned about the resident receiving Abilify and its potential to harm the resident. He stated the resident did not experience a significant negative outcome as result of the medication error. He added he would expect medication aides to properly determine the identity of a resident before administering medications and added he would have expected the facility to update picture identification for all residents on the MAR when they transitioned to using medication aides.	F 333	"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 provisions of Federal and State law."	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	F 441 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #7 by providing NA #2 with immediate training by the Director of Nursing regarding the transport of soiled linen and disposal of soiled incontinence supplies. Further, the equipment potentially contaminated was cleaned under the supervision of the Director of Nursing.	

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

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F 441	Continued From page 13 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and staff interviews the facility failed to properly contain an incontinence brief and a towel soiled with feces for 1 of 1 observations of incontinence care, Resident #7. The findings included: A facility policy entitled Perineal care of the female patient dated 10/06/12, read in part: "Equipment - trash bag. Dispose of soiled articles	F 441	2. Facility residents who receive assistance with Activities of Daily Living (ADLs) have the potential to be affected by this same alleged deficient practice; therefore, the Director of Nursing and/ or Unit Coordinator/ Manager and/ or Staff Development Coordinator will complete an audit of current residents to identify those residents receiving assistance with incontinence care. This audit will be completed on or before 2-14-13. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service for facility nursing staff by the Director of Nursing and/ or Staff Development Coordinator regarding the containment and disposal of soiled linen and incontinence supplies. The Director of Nursing, Unit Coordinator/ Manager and/ or Staff Development Coordinator will conduct care rounds at least three (3) times per week for a period of 90 days and randomly thereafter to validate appropriate infection control "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 provisions of Federal and State law."	

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F 441	Continued From page 14 in the appropriate receptacle." An observation of incontinent care was made on 01/17/13 at 2:20 PM. Nursing Assistant #2 performed incontinence care for Resident #7. During incontinence care Resident #7 was noted to have had a loose bowel movement. Her brief was soiled and saturated with stool. NA #2 removed the soiled brief and placed the brief in the resident's wheel chair. NA #2 did not fold or try to contain the contents on the brief. Resident #7's slippers were sitting in the seat of her wheelchair as well as the foot rests for the wheelchair. NA #2 also placed a towel which was visibly soiled with stool in the wheelchair seat. NA #2 needed to leave the room to obtain more supplies for cleaning the resident. NA #2 picked up the brief and the soiled towel and exited the room. An interview was conducted on 01/17/13 at 2:25 PM with NA #2. NA #2 stated she should have made sure she had a trash can or a trash bag to put the soiled brief in. She stated she should not have placed the soiled items in the resident's wheelchair. An interview was conducted 01/17/13 at 4:05 PM with the Staff Development Coordinator (SDC). The SDC stated the expectation was for staff to uses a trash bag for soiled linen and soiled incontinent briefs. He stated the soiled brief should not have been placed in the wheelchair. An interview was conducted on 01/17/13 at 4:45 PM with the Director of Nursing (DON). The DON stated it was her expectation for nursing assistants to use trash bags to contain soiled	F 441	techniques are being used. Any negative findings will be immediately corrected. 4. The Director of Nursing and/ or Administrator will analyze the data for trends and patterns. The Director of Nursing and/ or Administrator will report the finding to a QA/PI Committee weekly for a period of four (4) weeks and then monthly. The QA/PI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on negative outcomes identified to ensure continued compliance. "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 provisions of Federal and State law."	

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F 441	Continued From page 15 briefs and linen.	F 441	"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 provisions of Federal and State law."	