MAY 3 1 2013

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

PRINTED: 05/17/2013
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
	345317	A. BUILDING ______ B. WING ______	C 05/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, interview with family members and record review the facility did not preserve the dignity of a dependent resident by the failure to comb Resident#124 ' s hair prior to leaving the facility for a medical appointment. This was evident in 1 of 6 residents in the sample who were dependent on staff for care. Findings included: Review of the MDS (Minimum data Set) assessment dated 4/4/13 for Resident #124 revealed the need for extensive assistance from staff for the completion of personal hygiene. Additionally, the MDS indicated moderate cognitive impairment.	F 241	F 241 1. Corrective action was accomplished for resident #124. Hair Care was provided to Resident # 124 when she returned to facility. 2. Facility residents who require assistance with combing hair have the potential to be affected by the same alleged deficient practice. Residents currently residing in the facility will be reviewed to determine the level of assistance needed to maintain a dignified appearance related to hair being combed by reviewing their careplans. 3. Systemic measures put into place to ensure the alleged deficient practice does not recur include : Nursing Staff will be re-educated by 5/30/13 regarding providing personal care that promotes the resident's dignity to include hair care. The Interdisciplinary Team (IDT) will review and address resident, family and staff concerns during morning meeting Monday through Friday to monitor for any concerns related to personal grooming to include hair care.	5/30/13
	Review of the careplan dated 3/20/13 revealed problems with ADL (activities of daily living such as bathing and personal hygiene) which required extensive to total care from staff. The approaches included assist or provide resident with ADL. Observation of Resident#124 at 9:15 AM on 5/1/13 with NA#4 (nursing assistant) and a driver from the transporting ambulance revealed the		Resident Council meeting minutes and care concerns will be reviewed by the Director of Nursing or Assistant Director **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Gaither
TITLE: Interim Administrator
(X6) DATE: 5/29/13

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.

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F 241	Continued From page 1 resident was sitting in a chair waiting to be transported to a medical appointment . Resident #124 then experienced an episode of urine incontinence. Resident ' s #124 hair was in a braided style and was separating out of the braids. The hair in the back of the resident's head was tangled and matted. Observation on 5/1/13 at 9:20 am revealed NA#4 and NA#5 provided incontinence care to the resident. The resident's hair was not combed and remained tangled and matted in the back with hair separating from the braids. At 9:30 am NA#5 assisted the ambulance driver to transport the resident out of the facility. Interview on 5/1/13 at 9:31 AM with NA#5 revealed she was assigned to the resident and had given the resident a shower. When inquiring about the resident's hair NA#5 stated that she was not allowed to comb the resident ' s hair because someone else (unsure who) usually does it. NA#5 indicated that the resident required staff to comb her hair. Interview on 5/1/13 at 9:35 AM with the director of nurses revealed she observed the uncombed hair of Resident's#124 while being transported in the ambulance. Interview on 5/1/13 at 12:30 pm with family members of Resident#124 was held. One family member indicated that prior to being sick and admitted to the facility Resident#124 always had her " hair combed and looking nice. " " I was upset when I came in today [referring to 5/1/13] and saw [name of Resident #124] hair matted and not combed. " The family indicated that	F 241	Resident Council meeting minutes and care concerns will be reviewed by the Director of Nursing or Assistant Director of Nursing for 3 months to identify residents who have concerns regarding hair care. Hair care observations will be conducted by the Director of Nursing, Assistant Director of Nursing or designee prior to appointments to ensure residents hair is groomed appropriately. Observations for residents dependent for hair care will be conducted daily for 2 residents for 2 weeks and then with 5 residents weekly for 2 weeks, then 5 residents monthly for 2 months. The Social Worker will conduct 2 interviews with alert and oriented residents daily for 1 week, 2 weekly times 3 weeks and 4 interviews monthly times 2 months to ensure the resident is receiving assistance with hair care and care is being provided in a dignified manner. Observations and interviews will be conducted on Saturday and Sunday by the Weekend Nursing Supervisor or the Manager on Duty. Results of the observations and interviews will be reviewed during the Interdisciplinary Team meeting Monday thru Friday. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 241	Continued From page 2 other staff have braided the resident ' s hair in the past. An unsuccessful attempt was made to interview Resident#124 on 5/1/13 at 12:55 pm. Interview on 5/2/13 at 6:07 PM with the MDS consultant, administrator and director of nurses was held. The administrator indicated that she expected the resident to be properly groomed when going out of the facility.	F 241	Negative findings will be addressed when noted. 4. The Director of Nursing will review the results of the observations and resident interviews analyze for patterns/trends and report findings to the Quality Assessment Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and will develop and implement additional interventions as needed to ensure continued compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff the facility failed to have handrails free from dust and debris, cove molding intact, walls and wall paper intact, handles intact on closet drawers and walls free from exposed plaster. This was evident on 3 of 4 resident care areas. (200, 300, and 400) Findings included: 1. Observation on 5/1/13 at 8:10 AM revealed handrails attached to the wall have a space between the rail and where the rail was attached to the wall. There was an accumulation of dust, dirt, crumbs and paper inside the space of the handrails attached to the wall near rooms 303, 304, 306, 308, and 307.	F 253	" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 253	Continued From page 3 Observation on 5/1/13 at 12 noon revealed an accumulation of dust and staples inside the space of the handrails near the activity dining room. In the space of the handrails near room 203 there was an accumulation of dust, a white stick and a gold colored plate. Observation on 5/1/13 at 3:35 PM through 4:15 PM revealed these handrails remained the same as 8:30 AM and 12 Noon. The space in the handrails near the dining area on unit 400 had an accumulation of dust and dirt with a white ring disc. Observation on 5/2/13 at 8:30 AM revealed the space between the handrails and the wall remained with an accumulation of dust, dirt and objects as noted on 5/1/13. At 11 AM on 5/2/13 the hand rails and environmental issues remained. Interview on 5/2/13 at 11:17 AM with HK#1 (housekeeper) working on the 300 wing revealed that the floor technician usually cleans the handrails and sometimes " we might do it. " " I have not cleaned the rails. " Interview on 5/2/13 at 11:20 AM with the HK#2 who worked 1/2 of 300 unit and unit 100 indicated that the floor tech usually cleans the rails and "I have not cleaned the rails." Interview and observations on 5/2/13 at 11:30 AM director of housekeeping (DOH) revealed "I cleaned the hand rails every week and whenever there was a need. " " We do not have a written protocol for cleaning the hand rails. " The DOH observed the status of the above handrails.	F 253	F253 1. The space between the handrails and the walls have been cleaned and are free of dust and debris. The plaster in rooms 213, 315, bathroom between 309 and 311 has been repaired. The cove base in rooms 215,315, 313, 112 was repaired or replaced. Wallpaper on the 200 hall is being removed. The light between 214 and 216 has been replaced. The handles to the drawers in room 214 were repaired on 4/29/13. 2. Residents currently residing in facility have the potential to be affected by the same alleged deficient practice. Corrective measures are as follows: A Protocol for cleaning handrails has been established and housekeepers will be inserviced by 5/30/13. All rooms have been checked by Administrator and Ambassadors and any plaster repairs and missing cove base has been completed. The existing wallpaper in resident care hallways has been removed. Any peeling wallpaper found in residents' rooms has been removed. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: During morning rounds M-F, Ambassadors **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/30/13

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F 253	Continued From page 4 These rails were in the same condition as noted above in previous observations. The DOH indicated that the floor tech cleaned the handrails on the 400 unit and 300 unit on 5/1/13. The floor technician was not available for interview. 2. Observation at 9:30 AM on 4/30/13 revealed the wall next to bed 213 A had 2 unfinished plastered walls. One measured appropriately 22" long and 81/2 inches wide. The second one measured approximately 81/2 inches wide and 11 inches long. Observation on 5/1/13 at 8:10 AM revealed cove molding was missing near the bathroom entrance in 215 B room. There was peeling wall paper in the 200 hallway near rooms 208, 206, 212 and 211. In room 315 B there was missing cove molding. The wall was torn with exposed plaster that measured approximately 5 inches in length and 1/2 inch wide. In room 313B the cove molding was detached from the wall. The bathroom shared by 309-311 had exposed plaster wall behind the commode. The plaster was rough. In room 112 there was missing cove molding near the closet. On 5/1/13 at 3:35 PM through 4:15 PM observations revealed no changes. Observation on 5/2/13 at 8:30 AM revealed the conditions remained. 3. Observation on 5/1/13 at 3:35 PM through 4:15 PM revealed the bathroom light flickered when turned on in bathroom shared by room 214-216. 4. Observation on 04/29/2013 at 3:51 PM	F 253	will check handrails for cleanliness and report. Maintenance repair needs will be documented in the "maintenance log book" located at the nursing station. In addition, all findings will be discussed and documented, Monday thru Friday, during the Interdisciplinary Team (IDT) meeting. The Maintenance Director will give an update of maintenance concerns Monday thru Friday during the IDT meeting. 4. The Maintenance Director and Nursing Home Administrator will review the "maintenance log book" and maintenance concerns to analyze for patterns/trends and report findings to the Quality Assessment Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and will develop and implement additional interventions as needed 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 the provisions of federal and state law."	

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F 253	Continued From page 5 revealed the drawers of closet 214 A and B have handles that were partially attached. Observations of the environment and interview on 5/1/13 at 11:45 AM with the director of maintenance revealed he was not aware of the status of room 315, the semi attached hardware on the closet drawers or the cove molding missing in rooms. He indicated that the procedure was to have nursing staff complete a maintenance request but he never received ones for the issues noted above. Interview on 5/2/13 at 6:07 PM with the MDS consultant, administrator and director of nurses was held. The administrator indicated that that she expected handrails to be clean but did not indicate how often the handrails should be cleaned. The administrator indicated that it was all facility staff's responsibility to report maintenance issues.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 279	Continued From page 6 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: F279 Based on observation staff and family interviews and medical record reviews the facility did not create a comprehensive care plan to address and treat a dependent resident who required specific and frequent mouth pain. This was evident on 1 of 2 residents reviewed for dental services. (Resident # 102) The findings Resident #102 was readmitted to the facility on 01/13 with diagnoses of Wernicke Encephalopathy, dementia, dysphagia, PEG (percutaneous enteral feeding gastrostomy tube), bed bound with lower extremity contractures. According to the Minimum Data Set (MDS) dated 05/02/13 Resident #102 was moderately, impaired for decision making, but able to make her needs known. She received continuous tube feedings, full liquid diet and could have pleasure fluids. She was dependent on the staff for all care needs including mouth care. During an interview with a family member on 05/01/13 at 3:30 PM revealed the resident's mouth was extremely painful. The resident was	F 279	279 1. Corrective action has been accomplished related to the alleged deficient practice in regards to resident #102. A care plan specifically for oral care was developed and validated that all interventions identified on the care plan were implemented. In addition the current pain care plan was updated to reflect specifically "oral pain" with corresponding interventions. 2. Facility residents have the potential to be effected by the same alleged deficient practice. A review of resident Care Area Assessments (CAA's) will be completed to identify those residents who have triggered an oral/dental CAA and Care Plans and cardexes will be implemented/updated according to individual's needs. The RCMD/MDS coordinator will review resident's latest MDS assessment to identify residents reporting pain and address the location of their pain to ensure applicable dental/oral conditions are identified and treated. 3. Systemic measures put into place to ensure that the alleged deficient practice does not recur include: Re-education for Licensed Staff regarding updating Care Plans/cardex with changes in resident's oral care needs **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/30/13

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F 279	Continued From page 7 seen by a dentist, placed on antibiotics and he informed me (family member) that she had exposed nerves in her gums causing constant pain. He recommended that she have her teeth removed. This has been scheduled in a few weeks. The family member continued that Resident # 102 gets a mucous like film on her teeth all the time, and it needs to be cleaned but it was painful for the staff to clean her mouth and teeth. The staff does not clean her mouth unless I ask them to do it. Her mouth always has the mucus film on her mouth and teeth when I come to visit her. The nurses are supposed to clean her mouth twice a day with a special mouthwash and the nursing assistants should clean it when they seen the film has built up. A review of the Kardex (internal document utilized by the NAs to know the care required for each resident) revealed there was no documentation indicating the resident required frequent mouth care. An interview with NA # 2 on 05/01/13 at 10:00 AM revealed the resident often refuses to have her mouth cleaned because it is painful. He continued she does get pain for mediation so when she complains the nurse is notified and the resident will get her medication. He stated " I never thought to go back after she received pain medication to see if she would allow me to clean her mouth " . There was no dental assessment in the medical record. The facility did not have a care plan to address her dental issues. Review of the care plan for ADLs (activities of daily living) there was no interventions to address	F 279	documentation and notification requirements will be completed by 5/30/13. Newly admitted residents will be reviewed daily (Monday thru Friday) during the Interdisciplinary Team meeting times 2 weeks to ensure oral care needs and dental concerns have been addressed if identified The Resident Care Management Director/MDS coordinator will address resident oral status upon admission and quarterly thereafter. If a change in oral condition is identified in between MDS assessments nursing staff will document the change in the nurse's notes and on the 24 hour report. The 24 hour reports will be reviewed daily, Monday thru Friday, during the Interdisciplinary Team meeting. The Licensed Nurse will also report the change to the MD and update the plan of care. These residents will then be discussed with the Interdisciplinary Team (IDT) during the morning meeting Monday thru Friday to determine if further interventions are needed. Ten assessments (5 admissions and 5 Long term care) will then be randomly reviewed monthly, times 3 months to ensure dental concerns have been addressed and care planned accordingly. Negative findings will be addressed if noted. 4. The Resident Care Management Director will analyze the results of the **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 279	Continued From page 8 mouth care for this resident with dental issues. An interview with the nurse #2 on 04/29/13 at 3:45 PM revealed the resident gets pain medication scheduled and PRN. She did not document if it was for mouth pain or for teeth pain, she just documented the resident had pain. She further indicated she does not like to have her mouth cleaned with the Peridex, she says it hurts. An interview 04/30/13 at 8:45 AM with to NA#2 indicted they (NA) try to clean her mouth but sometimes she does not let them because it is painful. They tell the nurse and if she is due for pain medication she gets it. An interview with the director of nursing (DON) on 05/01/13 at 3:50 PM revealed Resident #102 had a dental consult on 04/04/13. She returned to the facility with an order for antibiotics for 10 days and mouth care with Peridex (medicated mouth wash) twice a day which was done by the nurses. She is scheduled to have her teeth extracted on May 13, 2013. She does develop a mucous film on her mouth and teeth and it needs to be cleaned frequently. She also has a feeding tube so mouth care should be done frequently to prevent her from getting a dry mouth. The NAs have indicated that she complains of pain when they clean her mouth in between the medicated mouth wash. She does receive scheduled pain medication and PRN (when necessary) pain medication, but there was no specific intervention to medicate the resident before the staff attempt	F 279	audits for patterns/trends. Results will be reported to the Quality Assurance and Performance Improvement committee monthly x 3 months. The Quality Assurance and Performance Improvement Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed 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 the provisions of federal and state law."**	

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F 279	Continued From page 9 to provide mouth care. This would make the resident more comfortable. After reviewing the nurses ' notes the DON indicated that there was no documentation that the resident had complaints of pain in her mouth, it just indicated the resident had pain. The DON indicated the nurses should have been more specific in the type of pain the resident was complaining of when she was medicated. She continued the NAs also should provide frequent mouth care and report to the nurse when the resident refuses due to pain. She stated " we should have a care plan specific for dental care for this resident especially since she was seen by a dentist and was scheduled for further dental work. An interview with the MDS Coordinator (minimum data set) on 05/01/13 at 2:30 PM revealed the resident will have a specific care plan for dental care after she had her teeth extracted, but indicated there should be specific interventions on her current ADL care plan or we could even develop a care plan specific for her mouth care. This information would then be placed on the Kardex for the NAs to know and provide frequent mouth care for Resident # 102.	F 279		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and	F 322	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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	345317	A. BUILDING ______ B. WING ______	C 05/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

(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 322	Continued From page 10 (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: F322 Based on observations, staff interviews and medical record reviews, the facility staff lowered the head of the bed of a resident receiving enteral feedings while the continuous tube feeding was infusing. This was evident for the only resident in the facility with a gastrostomy feeding tube. Resident # 102 The findings included: Resident #102 was readmitted to the facility on 01/13 with diagnoses of Wernicke Encephalopathy, dementia, dysphagia, PEG (percutaneous enteral feeding gastrostomy tube), bed bound with lower extremity contractures. According to the Minimum Data Set (MDS) dated 05/02/13 Resident #102 was moderately, impaired for decision making, but able to make her needs known. She received continuous tube feedings, full liquid diet and could have pleasure	F 322	F322 1. Corrective action was accomplished for Residents # 102. The Director of Nursing (DON) on 04/29/13 elevated the head of the bed. Resident care cardex was updated on 4/29/13 to indicate the head of the bed is to be elevated when the tube feeding is infusing. 2. Facility residents who receive continuous infusion of tube feeding have the potential to be affected by the same alleged deficient practice. We have one resident who was educated on the head of bed elevated. A wedge cushion placed between mattress and bedframe. 3. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: A wedge cushion was placed between mattress and bed frame on 5/07/13 to ensure head of the bed was elevated. Re-education for Nursing staff to include the rationale for the head of bed being elevated with residents receiving continuous infusion of tube feeding will be completed by 5/30/13. Ambassadors will make observation rounds Monday thru Friday to ensure the head of the bed is elevated as indicated. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	5/30/13

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F 322	Continued From page 11 fluids. She was dependent on the staff for all care needs including turning and repositioning, incontinent care and personal hygiene. A review of the nursing assistant (NA) care sheet (Kardex, an internal document used by the NA to provide care for the residents) revealed resident head of bed was to be elevated 45*(degree) at all times. Review of the Care Plan for Enteral Nutrition: in part: " related to: Impaired Swallowing. Interventions/approaches: Elevate HOB. May lower at short intervals to provide ADL care " . An observation on 04/29/13 at 3:05 PM revealed the resident lying on her right side in bed with her contracted legs supported by pillows. The head of the bed was noted to be elevated aproximately15* (which was less that the 45* ordered). The bed controls were noted to be on the left side of the bed affixed on the side rail. Resident #102 had a tube feeding infusing at 55 ml/hr (milliliter per hour) continuously. She was observed vomiting yellow liquid resembling the tube feeding. A family member was at her bedside helping her by wiping up the vomit in a cloth. The family member indicated he was taking care of her, he pushed the call bell for assistance. There was no staff in the hallway, the director of nursing (DON) entered the room at 3:20 PM and observed the resident and immediately raised the head of the bed 45*. She stated " the head of the bed should be elevated at all times " . An interview on 04/30/13 at 10:50 AM via telephone with NA#1 who cared for the resident on 04/29/13 revealed the head of bed must	F 322	Negative findings will be addressed when noted. Ambassadors are to document negative findings for discussion during the Interdisciplinary Team meeting Monday thru Friday for 2 weeks. The Weekend Nursing Supervisor will conduct observations and document findings on the weekends for 2 weeks. Observations will then be monitored by the resident's Charge Nurse and Resident Care Specialist. Negative findings will be corrected and reported to the Director of Nursing for review. 4. The Director of Nursing will review the results of the observations and resident interviews analyze for patterns/trends and report findings to the Quality Assessment Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and will develop and implement additional interventions as needed 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 the provisions of federal and state law."	

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F 322	Continued From page 12 always be elevated due to her getting the feeding tube. He stated he only cared for the resident in the morning on 04/29/13. An interview on 04/30/13 at 9:32 AM with NA#2 revealed Resident # 102 was contracted and can use her hands to grab the side rails when turned. He did not know her to ever put the head of her bed down using the bed controls. He continued the HOB (head of bed) must be kept at 45* angle at all times due to aspiration of G-tube feeding. A telephone interview on 04/30/13 at 10:20 AM with Nurse #1 who cared for Resident # 102 on 04/29/13 revealed she had administered the resident ' s medications via the G-tube. The head of bed was supposed to be at 30*. She stated " when I went to administer the resident ' s medications yesterday (04/29/13 at 10:30-11AM) I saw the HOB was not elevated, the resident was lying almost flat, I elevated it before I gave her the meds and then I left the room " . She continued maybe after the NAs changed and repositioned Resident # 102 they may not have raised the HOB. A telephone interview on 04/30/13 at 10:25 AM with NA#3 revealed she repositioned Resident # 102 at about 2:30 PM yesterday (04/29/13) and the resident asked her to lower the head of her bed. Therefore, before she left the room, she lowered the head of the bed for the resident so she could sleep. NA#3 indicated the resident was facing the window and the controls were located on the opposite side of the bed. She was not aware that she should not have lowered the head of the bed. She stated she had worked with this	F 322	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

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F 322	Continued From page 13 resident before but must have forgotten not to lower the head of the bed. An interview with the DON on 04/30/13 at 10:44 AM revealed her expectation was the HOB was to be elevated at all times. She stated she felt the G-Tube can stay on (continuously running) even if the staff were just repositioning the resident. She further stated she considered a short interval was just for repositioning or performing her personal hygiene, incontinent care. She then clarified her expectation and stated " the tube feeding should be turned off when the resident was having any care provided that required the HOB to be lowered to avoid aspiration of the feeding. " She indicated the staff was currently not turning off the G tube when the HOB was lowered. The DON explained the staff would know the care needs of a resident by the information on the Kardex. The resident ' s Kardex did indicate the Head of bed should be elevated at 45* at all times, but it needed to be changed to turn the tube feeding off when HOB was needed to be lowered.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and	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 the provisions of federal and state law."	

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F 323	Continued From page 14 record review the facility failed to have handrails that were free from chipped, rough and splintered areas. This was noted in 4 of the 4 resident units within the facility. (Units 100, 200, 300 and 400) Findings included: Observations during an environmental round on 5/1/13 at 8:30 AM revealed chipped handrails on the 300 hallway. The corners of the handrails near rooms 311, 307 and 309 were chipped, rough and splintered. The handrails throughout the 200 unit were chipped with rough areas. Observation on 5/1/13 at 3:35 PM through 4:15 PM these handrails remained in the same condition as noted at 8:30 AM. Continued observations on the 100 hallway revealed chipped, rough and splintered handrails. There were splintered and rough handrails near rooms 410 and 407. Observations of the hand rails and interview on 5/1/13 at 11:45 AM with the director of maintenance revealed the above chipped, rough and splintered handrails remained. Interview at the time of the observation with the maintenance director revealed he thought that the rails were just chipped. At 1 PM the administrator joined the observation of the hand rails. The administrator indicated that she believed the chipped areas were rough not splintered. Review of the last monthly inspection report dated 4/12/13 for the handrails revealed an inspection of the handrails being secure to the wall and capable of supporting 250 pounds. There was no indication that the facility addressed the rough	F 323	F 323 1. There were no residents identified as being affected. The handrails on 100, 200, 300 and 400 halls will be sanded and painted to remove any areas that may be chipped or rough. 2. Other residents currently residing in the facility have the potential to be affected by the same alleged deficient practice. The handrails in all patient care areas are scheduled to be sanded and painted. 3. Systemic measures to ensure the same alleged deficient practice does not recur include: Maintenance Director will inspect the hand-rails daily, Monday thru Friday, for any areas that may be chipped, rough or splintered. Negative findings will be addressed if noted. The Maintenance Director will document and report findings daily, Monday thru Friday, during the Interdisciplinary Team meeting. 4. The Maintenance Director and Nursing Home Administrator will review the results of the audits to analyze for patterns/trends and report findings to the Quality Assessment Performance **"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	5/30/13

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F 323	Continued From page 15 and chipped handrails. Observation on 5/2/13 at 11 AM revealed the hand rails remained chipped, rough and splintered. Interview on 5/2/13 at 6:07 PM with the MDS consultant, administrator and director of nurses was held. The administrator indicated that the handrails needed touching up and the hand rails were just painted (referring to 5/2/13).	F 323		
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	345317	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/06/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K052 The alarm audible, visual device next to Room 108 was replaced on 6/12/2013 so that it now has both visual and audible alarms.	6/12/13
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/6/13 at approximately noon the following fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm audible visual (AV)device (horn and strobe) next to room 108 did not sound the alarm signal. The visual operated properly, the audible did not operate properly.	K 052	To identify any other life safety issues with the potential to affect residents in the same manner, the alarm audible/ visual devices throughout the facility were checked. All devices were found to be working properly. During monthly fire drills, the Maintenance Director will monitor each alarm to ensure that it is working properly. Any adversefindings will be reported to the Administrator and corrections will be made immediately. Maintenance Director will report findings of the monthly monitoring during theMonthly Safety Meeting ongoing. Date of corrective action: June 12, 2013 "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathryn B Gaither	Interim Administrator	6/14-13

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.