

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

PRINTED: 04/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345345	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2015
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & RETIREMENT/MONROE	STREET ADDRESS, CITY, STATE, ZIP CODE 204 OLD HIGHWAY 74 EAST MONROE, NC 28112
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident, family and staff interviews and record review the facility failed to answer the call light and provide toileting assistance for one of three sampled residents. (Resident #47)</p> <p>The findings included:</p> <p>Resident #47 was admitted to the facility on 9/26/14 with diagnosis of renal failure, diabetes, bilateral upper extremity paralysis.</p> <p>The quarterly Minimum Data Set (MDS) dated 12/29/14 indicated Resident #47 was alert and oriented with no memory impairment. The MDS assessed extensive assistance was required by staff for bed mobility, transfer, personal hygiene and toileting. Resident #47 had occasional urinary incontinence and always incontinent of bowel.</p> <p>The care plan updated on 12/30/14 included a problem of incontinence with approaches to provide perineal care as needed, have call light within easy reach, observe for incontinence episodes at regular and frequent intervals as needed.</p> <p>Interview with Resident #47 on 2/27/15 at 1:00 PM revealed he had to wait an hour for staff to</p>	F 241	<p>The call light for Resident #47 was evaluated by the Director of Nursing on February 27, 2015 and found to be properly functioning. Aide #1 was re-educated by the Director of Nursing on March 2, 2015 regarding timely response to call lights and providing for the resident's dignity when conducting care.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>The Staff Development Coordinator will re- educate all Nursing Staff regarding timely response to call lights and providing for the resident's dignity when conducting care. This re-education will be completed by March 27, 2015.. The Director of Nursing or Assistant Director of Nursing will randomly interview and observe 10 residents weekly for 4 weeks and monthly for 2 months to verify timely response to the call light and maintenance of dignity while providing care. Opportunities for improvement will be corrected as identified.</p> <p>The results of these observations and reviews will be reported during the</p>	3/27/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/27/2015
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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 answer his call light. He needed to go to the bathroom. Resident #47 stated he went to the bathroom in his disposable brief. He knew it took an hour by the clock beside his bed. He explained it happened a week ago. That was the only time it had happened. Interview with a family member who visits frequently was conducted on 2/27/15 at 1:10 PM. The family member was visiting last week and staff did not come for an hour to change the Resident's brief. The family member further explained he had used his disposable brief, and that "upsets him." On 02/27/2015 at 1:21 PM an interview was conducted with aide #1. Interview with aide #1 revealed she had provided care for Resident #47. Aide #1 explained he knew when he needed to go to the bathroom. He uses a urinal and bedpan. Interview with the Administrator on 2/26/15 at 12:45 PM indicated he expected all staff to answer the call bells. If the person answering the call bell could not provide the care, they were to obtain assistance for the resident. He would expect staff to answer call bells before a thirty minute timeframe. He was not aware of any resident having to wait 30 minutes or longer.	F 241	monthly QAPI meeting by the Director of Nursing. The committee will evaluate and make recommendations as indicated. Date of Compliance: March 27, 2015		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		3/27/15	

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F 250	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and pharmacy consultant interview the facility failed to follow physician order for 1 of 1 Resident (Resident #180) that required psychiatric consultation.</p> <p>The findings included;</p> <p>Resident # 108 was admitted to the facility on 10/23/14 with a diagnosis that included; mixed hyperlipidemia, hypothyroidism, hypertension, atrial fibrillation and history of prostatic malignancy. The most recent Minimum Data Set (MDS) Assessment dated 1/26/15 indicated Resident #108 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4.</p> <p>Review of Resident #108's care plan updated 1/15/15 revealed a "problem" of, "depression/anxiety/sad mood." The goal stated Resident #108 would have indicators of altered mood decreased to no more than 0 episodes per day, and 0 per week through next review. The approaches included; provide a calm environment, encourage resident and staff to be alert to events or situations that precipitate episodes of restlessness or anxiety; encourage resident to express feelings, provide counseling via social services, psych services, or clergy if desired and notify medical doctor as needed. Further review of Resident 108's care plan revealed a "problem" of, "required administration of psychoactive medication" due to a diagnosis of depression, insomnia and anxiety. Mood indicators were identified as sleeplessness,</p>	F 250	<p>The Physician's Order for Resident #108 for Psychiatric evaluation was discontinued by the Physician on February 28, 2014 due to refusal by the family and identification of diagnosis of Depression located on the original Hospice History and Physical dated October 23, 2014 in the medical record.</p> <p>All residents with Physician's orders for Psychiatric consultation have the potential to be affected by this alleged deficient practice.</p> <p>The Director of Nursing and Social Services Director conducted an audit of current resident's charts to validate the completion of Psychiatric evaluations as ordered. This audit was completed by March 27, 2015.</p> <p>The Director of Nursing and Assistant Director of Nursing will re-educate the Social Services Director and Licensed Nurses on receiving and completing Physician's orders for Psychiatric evaluations. This education will be completed by March 27, 2015.</p> <p>Director of Nursing and Assistant Director of Nursing will review new Physicians all orders 3 times per week for 12 weeks to validate the completion of Psychiatric evaluations as ordered. Opportunities will be corrected as identified.</p>		

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F 250	<p>Continued From page 3</p> <p>sadness, and isolation. The goal stated, "Resident #108 would receive medications at smallest dosage that continues to be effective though next review". The approaches included; periodic reviews of medications by interdisciplinary team to determine potential dose reductions, observe for potential side effects of medication administered, and psych service as ordered.</p> <p>Resident #108's initial medication regimen review dated 11/20/14 indicated Vanlataxine (medication used for depression) 150mg (milligrams) daily with no corresponding diagnosis identified.</p> <p>Review of Resident #108's pharmacy recommendations dated 11/20/14 stated after reviewing Resident #108's chart, there appears to be no diagnosis and/or documentation the residents record which supports continued use of the following medications: 1) venlafaxine. The recommendations indicated, please re-evaluate continued use, or provide communication on this paper or in the resident record which supports the clinical rational for routine use of this medication moving forward. The pharmacy recommendation was signed by the medical doctor on 12/19/14 and states psych consult to evaluate.</p> <p>Review of Resident #108's physician order per pharmacy and physician dated 12/31/14 stated; psych consult for diagnosis of vanlafaxine use. The physician order is signed by physician on 1/5/15.</p> <p>Interview with the Social Worker on 2/25/15 at 2:49 pm revealed he was responsible for making referrals when a resident had a need to be seen</p>	F 250	<p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing. The committee will evaluate and make recommendations as indicated.</p> <p>Date of compliance: March 27, 2015</p>		

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F 250	<p>Continued From page 4</p> <p>by psych. The Social worker indicated he received referrals from the doctor as evidenced by receiving the pink copy of the physician order. The Social Worker continued that he would make the arrangements with the resident's responsible party and the outside psych agency. The resident would typically be seen within 2 weeks of the approval for the services. Following a resident being seen by psych, the social worker would receive an email or a consult would be provided in person. All consults would be located within the resident's medical cart. The social worker indicated he could not recall if Resident #108 had a physician order for a referral for psych services. The social worker could not locate a consult that would indicate Resident #108 received psych services.</p> <p>Interview with the Director of Nursing (DON) on 2/25/15 at 3:05 pm revealed the social worker would be responsible for coordinating psych services for residents. The nurse would put a copy of the physicians order in the social workers box. If the order comes though pharmacy then it would go to the physician for his review. The DON continued that it was her expectation that resident #108 receive the psych services as ordered. It was further her expectation that the resident be seen within 2 weeks of the referral.</p> <p>Interview with the Pharmacy Consultant on 2/25/15 at 3:19 pm revealed she had identified that Resident #108 had not had a diagnosis for the use of valfexine when she did the initial medication regimen review. The Pharmacy Consultant indicated that she did provide the facility with pharmacy recommendations on 11/20/14. The consultant pharmacist stated on 12/31/14 a conversation was had with the</p>	F 250			

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F 250	Continued From page 5 physician. The consultant indicated that following the conversation the physician revealed he was not comfortable providing Resident #108 with a diagnosis for the continued use of the medication Valfexine. As a result the Pharmacy Consultant and the physician wrote the order for the resident to be seen by psych in an effort to identify a diagnosis for the continued use of valfexine. The Consultant Pharmacist indicated it was her expectation that the resident be seen by psych according to the physician order.	F 250			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		3/27/15	

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F 280	<p>Continued From page 6</p> <p>Based on observations, interviews and record reviews, the facility failed to update the care plan for 1 of 2 residents reviewed for thickened liquids. (Resident # 37)</p> <p>The findings included:</p> <p>Resident #37 was admitted to the facility on 7/11/2011 with diagnosis of hypertension, diabetes mellitus and dementia.</p> <p>The Minimum Data Set (MDS) with an assessment reference date of 12/1/14 indicated that Resident #37 required extensive assistance with activity of daily living (ADL ' s) and was moderately cognitively impaired.</p> <p>The care plan updated on 2/20/15 revealed a problem for weight loss/nutritional risk with approaches that included mechanical soft diet with nectar thick liquids and adaptive equipment with divided plate and Provale cup (a cup designed to deliver " small swallows " (specific pre-determined volume) of thin liquid).</p> <p>A review of the speech therapy progress note dated 12/9/13 indicated that Resident #37 is now tolerating her diet with 85% accuracy. This includes drinking thin liquids through a Provale cup.</p> <p>An observation on 2/25/15 at 2:45 PM revealed Resident #37 in her room in wheel chair with ice water at her side.</p> <p>An interview with Nurse Aide (NA) #3 on 2/25/15 at 3:00 PM indicated that Resident #37 had a special cup and it was being washed. NA #3 further indicated that the resident care needs are</p>	F 280	<p>The Care Plan for Resident #37 was updated by the Director of Nursing to reflect the accurate consistency of liquids on February 27, 2015.</p> <p>All residents receiving thickened liquids have the potential to be affected by this alleged deficient practice. The Director of Nursing and Assistant Director of Nursing will complete an audit of resident currently receiving thickened liquids to validate accurate documentation of fluid consistency. This audit will be completed by March 27, 2015.</p> <p>Licensed Nurses will be re-educated by the Director of Nursing and Assistant Director of Nursing regarding updating care plans with accurate fluid consistency. The education will be completed by March 27, 2015.</p> <p>The Director of Nursing and Assistant Director of Nursing will review 5 charts weekly for 4 weeks and monthly for 2 months to validate accurate care planning of fluid consistencies. Opportunities will be corrected as identified.</p> <p>The results of these observations and reviews will be reported during the monthly QAPI meeting by the Director of Nursing. The committee will evaluate and make recommendations as indicated.</p> <p>Date of Compliance March 27, 2015</p>		

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F 280	Continued From page 7 obtained from the assignment sheet which indicated that Resident #37 should have a Provale cup at bedside for liquids. During an interview with the speech therapist on 2/25/15 at 3:30 PM revealed that Resident #37 is safe to use a Provale cup, she has been off thickened liquids for some time. The cup should be at her bedside and on her meal tray. During an observation at lunch on 2/27/15 at 12:30 PM revealed Resident #37 with thin liquids on her tray being served water in a Provale cup. An interview with the director of nurses on 2/27/15 at 1:30 PM indicated that Resident #37 has not been on thickened liquids since 9/1/14 upon readmission to skilled nursing from assisted living. The physician order sheet did not get changed and the care plan was not updated. The director of nurses further indicated that during clinical meeting each morning new orders are reviewed and the care plans and NA assignment sheets are updated at that time.	F 280			
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	F 431		3/27/15	

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F 431	<p>Continued From page 8</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired multidose vials of insulin from one of three medication carts and failed to date and use a pharmacy medication label for an insulin in one of three medication carts.</p> <p>The findings included:</p> <p>a. Observations on 02/27/2015 at 11:21 AM of the medication cart for the 100/300 hall residents revealed two expired multidose vials of insulin that were expired. A humalog insulin dated as</p>	F 431	<p>All expired drugs were discarded immediately by the Director Nursing on February 27, 2015 following identification.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>An audit of all medication storage rooms, refrigerators and medication carts was conducted and completed on March 23, 2015 by the Director of Nursing and the Assistant Director of Nursing. All expired or opened and unlabeled items identified were discarded immediately.</p>		

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F 431	<p>Continued From page 9</p> <p>opened on 1/29/15 and an expiration date of 2/26/15. A levemir insulin dated as opened on 1/23 with no expiration date written on bottle. The insulin would have expired on 2/21/15. The levemir insulin had been administered that morning by the night shift nurse.</p> <p>Interview with nurse #1 on 02/27/2015 at 11:23 AM revealed she had not given either insulin that day and was off the previous day. The Levemir insulin had been given prior to the resident going to dialysis by the night shift. The humalog was on a sliding scale and had not been administered for the past several days according to the medication administration record. She had not looked at the vials since she did not have to administer the medication.</p> <p>b. Observations on 02/27/2015 at 11:21 AM of the medication cart for the 100/300 hall residents revealed an prefilled insulin "kwikpen." The kwikpen had been labeled with a permanent marker with the resident's name and date it had been opened. The kwikpen was kept in a plastic bag with no pharmacy label containing the name of the resident, the medication, instructions for administration or date it had been sent.</p> <p>Interview with nurse #1 on 02/27/2015 at 11:23 AM revealed the kwikpen was from a box of insulin kwikpens kept in the refrigerator. The box contained the pharmacy label and there were not individual labels for the kwikpens once removed from the box. Nurse #1 stated it should not have been labeled by a nurse and a peel off label should have been provided by pharmacy.</p> <p>Interview with the Director of Nursing on 02/27/2015 at 11:50 AM revealed the system to</p>	F 431	<p>The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will re-educate Licensed Nurses regarding the policy and procedure for labeling and storing medications by March 27, 2015. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will audit all medication storage rooms, refrigerators and medication carts weekly for 12 weeks to verify medication storage per policy. Opportunities will be corrected as identified.</p> <p>The results of the audits will reported monthly in the QAPI meeting by the Director of Nursing. The committee will evaluate and make further recommendations as indicated.</p> <p>Date of Compliance: March 27, 2015</p>		

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F 431	Continued From page 10 check for expired medications included the night shift nurses were to check for expired medications. The insulins were missed. The kwikpen should have a labile from the pharmacy. She did not have an explanation as to why a nurse wrote the resident's name on the kwikpen.	F 431			