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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLAUSE IDENTIFICATION NUMBER:

345345

(X2) MULTIPLE CONSTRUCTION COMPLETED

A. BUILDING

B. WNG

(X3) DATE SURVEY COMPLETED

08/16/2011

NAME OF PROVIDER OR SUPPLIER

BRIAN CENTER HEALTH & RETIREMENT/MONROE

STREET ADDRESS, CITY, STATE, ZIP CODE

204 OLD HIGHWAY 74 EAST

MONROE, NC 28112

(X4) ID

PREFIX

TAG

ID

PREFIX

TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

F 225

SS=0

483.13(c)(1)(ii)-(iii), (c)(2)-(4)

INVESTIGATE REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F 225

1. Corrective action has been accomplished related to the alleged deficient practice in regards to Resident #12. The 24 hour initial report and 5-working day report was completed by the Director of Nursing (DON) on June 16, 2011 and submitted to the Health Care Personnel Registry (HCPR), on June 16, 2011.

2. Current facility residents have the potential to be affected by the alleged deficient practice. Staff Development Coordinator (SDC) and DON began to in service staff on June 16, 2011, regarding "Abuse Policy: Types of abuse, when to report, who they report to and investigation procedure." Administrator/Director of Nursing (DON)/Assistant Director of Nursing (ADON) reviewed incident accident reports and concern reports through April 2011 to determine any indications/allegations of abuse or incidents/accidents of unknown origin. A 24-hour report and 5-day investigative report will be completed and submitted to the HCPR for issues identified that may not have been reported previously.

3. Measures put into place to ensure that the alleged deficient practice does not recur: Staff development coordinator

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE

ADMINISTRATOR

7/8/11

FORM CMS-2567(02-09) Previous Versions Obsolete
EventID: Y98K11
FacilityID: 022087

RECEIVED
JUL 11 2011
BY: NR
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to submit the 24-Hour Initial Report and 5-Working Day Report to the Health Care Personnel Registry (HCPR) in one (1) of two (2) sampled investigations for injury of unknown origin (Resident #12).

The findings are:
Resident #12 was admitted on 8/3/09 with diagnoses which included Alzheimer's Disease, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Resident #12's annual Minimum Data Set dated 5/11/11 assessed short and long term memory problems and the extensive assistance of two persons for transfers.

Review of a Change of Condition form dated 6/3/11 revealed on-call Nurse Practitioner notification at 10:30 PM by Licensed Nurse (LN) #4 of bruises on Resident #12's chest and left arm.

Review of the facility's investigation dated 6/6/11 revealed the Assistant Director of Nursing (ADON) conducted an investigation of the bruising on 6/6/11. The investigation concluded there was no substantiation of abuse or neglect.

Review of the Family Nurse Practitioner's (FNP) visit dated 6/9/11 revealed the assessment of "bruising of unknown origin" and the following documentation: "linear bruising across pt's (patient's) upper torso, right breast and lateral the greatest; however noted some completely healed"

(SDC) and DON provided in service education beginning June 16, 2011 for staff regarding "Abuse Policy: Types of abuse, when to report, who they report to and investigation procedure." The Abuse Policy will be reviewed quarterly with current employees, and during orientation for new employees.
Administrator/DON/ADON will review Incident/Accident reports and concern reports daily Monday through Friday beginning June 16, 2011, to determine indications of abuse or injuries/accidents of unknown origin. Administrator and DON will follow up within 24 hours of reported allegation of abuse, or injuries of unknown origin. The 24-hour report and 5-day investigative report will be completed by the Administrator and DON within the timeframe and submitted to the appropriate State facility (HCPR) with proof of fax transmission to accompany the report.
Administrator/DON/Social worker will conduct interviews with at least 3 residents per week x 4 weeks then at least 3 residents monthly ongoing regarding care and treatment received. Issues identified will be handled according to the Abuse Policy.

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Continued From page 2

bruising both arms in alignment with torso bruise."

Interview with the Director of Nursing (DON) on 6/18/11 at 10:55 AM revealed LN #4, currently on vacation, completed an incident report and did not notify her of the incident when it occurred on Friday, 6/3/11. The DON explained it was the facility's policy for licensed nursing staff to call the DON with injuries of unknown origin. The DON explained an investigation should be started immediately and she was responsible for HCPR notification. The DON reported the 6/3/11 incident report, placed in the ADON's facility mailbox on a Friday evening was not read until 6/6/11. The investigation occurred on 6/6/11. The DON reported the 24-Hour Initial Report and the 5-Working Day report were not submitted to the HCPR because the investigation concluded no sign of abuse or neglect.

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and record review, the facility failed to notify the physician of nasal spray refusal for one (1) of twelve (12) sampled residents (Resident #12). The findings are:

Resident #12 was admitted on 8/3/09 with diagnoses including Chronic Obstructive
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| F 281  |        |     | Continued From page 3  
Pulmonary Disease. Resident #12's annual Minimum Data Set dated 5/11/11 assessed short and long term memory problems with severely impaired decision making skills.  
Review of physician's orders dated 6/2/11 revealed medications included Fluticasone nasal spray 50 micrograms (for allergic nasal symptoms) two sprays to each nostril daily.  
There was no documentation of Fluticasone nasal spray refusals.  
Review of the Fluticasone pharmacy label revealed a dispense date of 2/13/11 of 120 metered sprays (a sixty day supply) with a hand written opened date of 3/1/11.  
Interview with Licensed Nurse (LN) #1 on 6/14/11 at 4:30 PM revealed Resident #12 could not follow directions consistently and frequently refused the Fluticasone nasal spray. LN #1 explained she thought other nurses notified the physician of the refusals.  
Observation on 6/15/11 at 8:12 AM revealed LN #2 administered two sprays to Resident #12's left nostril and one spray to the right nostril. Resident #12 refused the second nasal spray.  
Interview with LN #2 on 6/15/11 at 6:40 AM revealed Resident #12 frequently refused administration of the nasal spray. LN #2 revealed she did not notify the physician of refusals.  

| F 281  |        |     | regarding omissions or refusals when identified.  
4. Director of Nursing will review and analyze data regarding notification of physician related to omitted or refused medications, identifying trends/patterns and report to Quality Assessment and Assurance Committee (Q&A) weekly for four weeks then monthly. The QA&A Committee will evaluate the effectiveness of the plan based on outcomes identified. The Committee will develop and implement additional interventions for negative trends to ensure continued compliance.  

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<tr>
<td>Interview with the Family Nurse Practitioner (FNP) on 6/16/11 at 8:30 AM revealed he was not aware of the Fluticasone refusals.</td>
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<td>Interview with the Director of Nursing (DON) on 6/16/11 at 9:10 AM revealed she was not aware of Resident #12’s refusal of the nasal spray. The DON explained the refusals should be documented on the MAR and the physician notified.</td>
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<td>Interview with the FNP on 6/16/11 at 2:15 PM explained he would evaluate the need for continuance of the nasal spray.</td>
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<th>F 312</th>
<th>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</th>
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<td>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.</td>
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This REQUIREMENT is not met as evidenced by:
- Based on observations, staff interviews and record review the facility failed to ensure that one (1) of five (5)sampled residents, who were dependent on staff, received needed staff assistance when eating. (Resident #8)

The findings are:
- Resident #8 was admitted to the facility on 11/14/09 and has diagnoses which include chronic debility, prior stroke and joint stiffness and pain. The resident was assessed on her...
**NAME OF PROVIDER OR SUPPLIER**

BRIAN CENTER HEALTH & RETIREMENT/MONROE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

204 OLD HIGHWAY 74 EAST

MONROE, NC 28112

**PREVIOUS RECORD NUMBER**

346346

**DATE SURVEY COMPLETED**

06/16/2011

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**F 312** Continued From page 5

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

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| F 312 | Continued From page 5 | Most recent Minimum Data Set (MDS) of 04/27/11 as having short term and long term memory problems, having moderately impaired cognitive skills for daily decision making and required extensive assistance with one (1) person physical assistance with eating. Review of the resident's plan of care, which was updated on 06/06/11, revealed a "Problem" related to "Weight Loss/Nutritional Risk". An approach within this plan of care directed nursing staff to feed Resident #8 her meals. On 06/14/11 at 5:48 p.m. staff was observed serving Resident #8 her evening meal in the facility's main dining room. After setting up the resident's meal tray staff was observed to offer her a spoon at 5:50 p.m. Resident #8 was observed to use a fork to place a large bite of food into her mouth, but the food was observed to back out the side of her mouth. A staff member wiped the resident's mouth and then left the resident feeding herself. From 5:53 p.m. to 5:57 p.m. Resident #8 was observed attempting to feed herself by placing large spoonfuls of food onto her spoon and bringing it to her mouth. In the process of attempting to feed herself Resident #8 was observed spilling foods onto herself and to have foods spill out from the left side of her mouth. At 5:57 p.m. a resident, who was eating next to Resident #8's at the dining room table, was observed to wipe foods from Resident #8's face. Observations from 5:57 p.m. to 6:02 p.m. revealed Resident #8's table mate continued to offer and provide Resident #8 with multiple bites of foods and to wipe foods from her mouth while she fed Resident #8. At 6:02 p.m. Nursing Assistant (NA) #2 was observed to redirect the resident away from feeding Resident #8.

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| F 312 | | | Feeding assistance needs. ST and FSD developed a seating chart on June 15, 2011, for residents in dining areas to accommodate positioning and feeding needs and seating chart posted in dining area. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Speech therapist provided in service education for nursing staff beginning June 16, 2011 regarding: "Assistance needed for residents during feeding and seating arrangements in dining area." DON, ADON, FSD and ST will monitor residents during meals three times per week for four weeks then weekly to assure residents receive assistance with meals as determined necessary and residents are seated according to seating arrangement and needs. 4. DON and/or ST will analyze for patterns/trends and report in Q&A meeting weekly for 4 weeks and then monthly thereafter. The Q&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.

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<td>#8 and staff then began to feed Resident #8. While being fed by NA #2 Resident #8 was observed to accept foods readily and have no difficulty.</td>
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<td>Interview with NA #2 on 6/14/11 at 6:50 p.m. revealed that Resident #8 does attempt to feed herself, but needs staff oversight and encouragement to ensure that she is feeding herself correctly and not spilling her foods. NA #2 further explained that when Resident #8 eats in the dining room she will usually sit at a different table than the table she was seated at during the evening meal of 08/14/11. NA #1 explained that when Resident #8 is seated at her &quot;regular&quot; table this allows staff watch her closer if she does attempt to feed herself.</td>
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<td>F 332</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
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<tr>
<td>SS=d</td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to maintain a medication error rate of less than five percent by not giving medications as ordered by the physician and according to manufacturer</td>
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<td>F 332</td>
<td>1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #12's Palmetol eye drops. Physician was notified on 6/15/11 by licensed nurse, regarding the potential extra drop into the right eye. No new orders were received. In service education was provided for licensed nurse by the Staff Development nurse (SDC) regarding administering eye drops according to physician orders. Physician was notified 6/15/11 by licensed nurse regarding Resident #15 and administration of Advair inhaler and effectiveness of inhaler. Physician discontinued Advair for Resident #15 on July 7, 2011. In service education was provided for the licensed nurse by the SDC regarding procedure for administering inhalers according to physician order. Physician was notified on 6/15/11 by licensed nurse regarding use of Combivent Inhaler for Resident #12. SDC provided in service education for licensed nurse regarding procedure for administering inhalers according to physician orders and manufacturers recommendations. On 6/20/11, physician ordered a mask to be used with the aero chamber for Resident #12 to improve effectiveness of medication. On July 7, 2011 the Physician discontinued the Combivent order for Resident #12.</td>
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F 332 Continued From page 7

Instructions. During observations of four medication passes three errors were detected in a total of fifty opportunities resulting in a 6% medication error rate. (Residents #12, Resident #14 and Resident #15)

The findings are:

1. Resident #14 was admitted to the facility on 02/16/10 with diagnoses including eye irritation.

During medication pass on 08/14/11 at 4:38 p.m. LN #3 administered Patanol eye drops one drop into the left (L) eye and two drops into the right (R) eye of Resident #14.

A medical record review revealed a physician order dated 06/02/11 for Patanol 0.1% one (1) drop to both eyes twice a day.

During an interview on 09/14/11 at 4:47 p.m. with LN #3 she stated one eye drop fell onto the left cheek of Resident #14 before she placed the eye drop into her (L) eye and she didn't realize two drops went into the resident's right (R) eye.

2. Resident #15 was admitted to the facility on 05/01/10 with diagnoses including chronic wheezing and shortness of breath.

A review of manufacturer's instructions for the use of a Advair Diskus inhaler stated to inhale before inhaling a dose of the Advair Diskus, breathe out as far as is comfortable, holding the Diskus level and away from the mouth. Put the mouthpiece to the lips and breathe in quickly and deeply through the Diskus, not through the nose, remove the Diskus from the mouth, hold the
F 332

breath for about ten (10) seconds and breathe out slowly.

During medication pass on 06/15/11 at 8:51 a.m. LN #3 was observed to place an Advair inhaler to Resident #15's lips. LN #3 told Resident #15 to "suck on the inhaler." Resident #15 was observed to suck on the inhaler and there was no visible inhalation or exhalation of breath while the inhaler was in her mouth. LN #3 removed the inhaler from the resident's lips and swabbed her mouth with a sponge saturated with water.

A medical record review revealed a physician order dated 06/02/11 for Advair 100-50 Discus one (1) puff inhalant every twelve hours.

During an interview on 06/15/11 at 8:56 a.m. with LN #3 she verified she told Resident #15 to suck on the inhaler and stated she leaned down next to the resident's mouth and heard her suck on it.

During an interview with the Family Nurse Practitioner (FNP) on 06/16/11 at 10:45 a.m. he stated a resident should inhale when an inhaler is administered. He further stated if a resident sucks on the inhaler like it's a straw it's not going to work. He explained sucking on it only pulled the medication into the resident's mouth and the medication did not go down into the lungs where it needed to go to be effective.

3. Resident #12 was admitted on 8/3/09 with diagnoses including Chronic Obstructive Pulmonary Disease.

Review of physician's orders dated 6/2/11 revealed medications included Combivent Inhaler two puffs four times daily and to use a spacer.

physician orders. Physician will be notified regarding discrepancies identified.

4. DON and/or SDC will analyze observations for patterns/trends and report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.

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F 332 Continued From page 9
(Combivent is a medication used to prevent shortness of breath and wheezing. When attached to the inhaler, a spacer provides easier medication delivery.)

Observation on 6/14/11 at 4:20 PM revealed Licensed Nurse (LN) #1 shook the Combivent Inhaler and asked Resident #12 to exhale. LN #1 administered one puff which Resident #12 inhaled quickly. After three minutes, LN #1 placed the inhaler to Resident #12's mouth, asked her to inhale and administered the second puff. LN #1 did not ask Resident #12 to exhale prior to the second puff dose and did not use the spacer which was available in the medication cart. (Exhalation deeply through the mouth prior to inhalation is the manufacturer's recommendation for full dose benefit.)

Interview with LN #1 on 6/14/11 at 4:30 PM revealed she forgot to ask Resident #12 to exhale prior to the second inhalation dose. LN #1 reported no reason for not using the spacer with the Combivent and explained Resident #12 was inconsistent with directions.

Interview with the Family Nurse Practitioner on 6/16/11 at 8:30 AM revealed the spacer should be used with every Combivent dose to ensure accurate administration for Resident #12.

F 441 483.55 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.

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(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, 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, record review and staff interview the facility staff failed to prevent contamination of the caps of two eye drop bottles and failed to clean a resident's finger before a

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| F 441 | | | 1. Corrective action has been accomplished for the alleged deficient practice in regards to the infection control program related to preventing the spread of infection. Staff development nurse (SDC) began in service education for licensed nurses on 6/15/11, related to providing barriers for items taken into resident room during medication pass and policy and procedure related to obtaining blood glucose test. 2. Facility residents have the potential to be affected by the same alleged deficiency. SDC began in service education on 6/15/11 for facility staff on 6/15/11 regarding: "Infection Control; Preventing the Spread of Infection. " Director of Nursing (DON), Assistant Director of Nursing (ADON) and SDC began medication pass observations on July 8, 2011, to assure infection control measures, such as barriers for items taken into resident rooms during medication pass were being utilized to prevent the spread of infection and proper cleaning of resident's skin prior to finger stick for blood glucose. Discrepancies identified will be corrected when observed.
3. Measures put into place to ensure that the alleged deficient practice does not recur includes: SDC began in service education for facility on 6/15/11 regarding: "Infection Control; Preventing the Spread of Infection." 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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finger stick blood sugar according to facility policy in two (2) of seven (7) residents observed during medication pass. (Resident #14 and Resident #15) 
The findings are:
1. Resident #14 was admitted to the facility on 02/16/10 with diagnoses of diabetes mellitus.
a. A review of a facility document titled “Passing medications” dated 2009 stated in part “it is important to use a barrier, such as a disposable tray or plastic cup, when carrying an inhaler, eye medication, or patch into the resident’s room and for storing the medication/container while administration is occurring.”
During a medication pass observation on 06/14/11 at 4:38 p.m. LN #3 removed the cap from a Patanol eye drop bottle for Resident #14 and placed the cap onto the resident’s overbed table. LN #3 administered the eye drops to Resident #14, put the cap with the contaminated side back on the eye drop bottle and put it back into the medication cart.
A review of physician orders dated 06/02/11 revealed Patanol 0.1% one (1) drop to both eyes twice daily.
During an interview with LN #3 on 08/15/11 at 9:02 a.m. she stated she had not received any specific instructions regarding where to place the caps of eye drops while administering eye drops to residents. She stated she thought she should have put it in a container and should not have placed it directly onto the overbed table.  

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| F 441  |        |     | of Infection.” SDC will provide ongoing in service education regarding infection control practices and preventing the spread of infection quarterly and during new hire orientation. DON, ADON and SDC will observe three licensed nurses per week for four weeks then two per week ongoing during medication pass to assure infection control practices are utilized to prevent the spread of infection. Discrepancies identified will be corrected when observed.  
4. SDC will analyze observations for patterns/trends and report in QA/AA meeting weekly for 4 weeks and then monthly thereafter. The QA/AA Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified.
Continued From page 12

During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m., she stated nurses should place the caps of eye drop bottles on a clean towel on the overbed table and the cap should not be placed directly onto the overbed table.

During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she explained nurses are required to watch a medication pass video during their orientation and they are provided an instruction sheet regarding the placement of a barrier when carrying eye medications into a resident's room.

b. A review of facility procedure titled "Blood Glucose Tests" from Lippincott, Williams and Wilkins 5th edition stated "wipe the puncture site with an alcohol pad, and allow to dry completely."

During a medication pass observation on 06/14/11 at 4:41 p.m. LN #3 went into Resident #14's room to perform a finger stick blood sugar. She put on gloves, removed a paper towel from the towel dispenser in the resident's room, wet it with water from the sink and wiped the resident's finger. LN #3 then stuck Resident #14's finger with a lancet and checked her blood sugar.

During an interview on 06/14/11 at 4:45 p.m. with LN #3 she confirmed she wiped Resident #14's finger with the wet paper towel. She further stated she was supposed to use an alcohol sponge to clean the resident's finger but she forgot.

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**Summary Statement of Deficiencies**

**F 441**

**Continued From page 13**

During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated nursing staff should use alcohol sponges to clean a resident's finger before performing a finger stick and they should not use a wet paper towel.

During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she stated nurses are expected to follow facility policy regarding cleaning a resident's finger before doing a finger stick blood sugar.

2. A review of a facility document titled "Passing medications" dated 2009 stated in part "It is important to use a barrier, such as a disposable tray or plastic cup, when carrying an inhaler, eye medication, or patch into the resident's room and for storing the medication/container while administration is occurring."

Resident #15 was admitted to the facility on 05/01/10 with diagnoses of a stroke.

A review of physician's orders dated 06/02/11 revealed Artificial Tears four (4) drops to both eyes four times per day.

During an observation during medication pass on 06/15/11 at 8:49 a.m. LN #3 removed the cap from a Liquid Tears eye drop bottle for Resident #15 and placed the cap down onto the resident's overbed table. LN #3 administered the eye drops, put the cap with the contaminated side back on the eye drop bottle and put it back into the medication cart.

During an interview with LN #3 on 06/15/11 at 10:30 a.m., LN #3 stated, "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."
F 441
Continued From page 14
9:02 a.m. she stated she had not received any specific instructions regarding where to place the caps of eye drops while administering eye drops to residents. She stated she thought she should have put it in a container and should not have placed it directly onto the overbed table.

During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated nurses should place the eye drop bottles on a clean towel on the overbed table and the cap should not be placed directly onto the overbed table.

During an interview with the Staff Development Coordinator in charge of infection control in the facility on 06/15/11 at 3:42 p.m. she explained nurses are required to watch a medication pass video during their orientation and they are provided an instruction sheet regarding placement of a barrier when carrying eye medications into a resident's room.

F 514
483.75(1)(1) RES
SS-D
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

F 514
1. Corrective action has been accomplished for the alleged deficient practice in regards to Advanced directive orders. Social worker discussed Advanced directives with Resident #5 for clarification and appropriate physician orders were obtained and Advanced Directives form completed by Social worker and resident on June _10__ , 2011. Monthly Physician orders dated July 2011, for Resident #5 were updated with accurate Advanced Directives.

2. Facility residents have the potential to be affected by the same alleged deficiency. Chart audit completed by Medical Records director and Social Worker (SW) for current residents on July _5__ , 2011. To identify residents with Advanced directives and physician orders to support the residents wishes. Advanced directive discrepancies identified were clarified, updated and physician orders were obtained as necessary and completed on July _7_ , 2011.

3. Measures put in place to ensure that the alleged deficient practice does not recur includes: In service education provided by Social worker (SW) beginning July 07 , 2011, for licensed nursing staff regarding completion of Advanced directive forms and obtaining Physician order to support Advanced directives. Social worker or Licensed nurse will review

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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

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td>F 514</td>
<td>Continued From page 15</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document do not resuscitate on the physician's orders for one (1) of twelve (12) sampled resident's. (Resident #5). The findings are: Resident #5 was re-admitted to the facility on 04/26/11 with diagnoses of atrial fibrillation, hyperlipidemia and urinary tract infection. Resident #5's re-admission Minimum Data Set (MDS) dated 06/06/11 specified she had short term and long term memory problems and was moderately impaired with cognitive skills for daily decision making. A review of the Department of Health and Human Services Do Not Resuscitate (DNR) form dated 04/26/11 and located in the front of Resident #5's medical record indicated do not resuscitate. There was no expiration date on the DNR form. A review of the Advance Directives/Medical Treatment Decisions Acknowledgment of Receipt form dated 04/26/11 and signed by Resident #5's medical durable power of attorney indicated do not resuscitate. A review of a hand-written physician order signed by Resident #5's physician and dated 04/26/11 stated do not resuscitate. A review of the printed monthly physician's orders for May and June indicated Resident #5 was a full advanced directives with new admitted and readmitted residents, obtain a signed Advanced directive form and Physician order to support the resident's wishes. Social worker or licensed nurse will review Advanced directives with resident and or family members quarterly, annually and significant change, update as necessary and obtain Physician order to support resident wishes. Medical records director will audit four charts per week x 4 weeks then ten charts per month to compare advanced directives to the physician orders for accuracy. Licensed nurse will review Advanced directives at the end of each month during order review to assure Advanced directives are accurate on the monthly Physician orders. Discrepancies identified will be reported to SW or licensed nurse to be corrected. 4. Social worker and Medical records director will analyze audits for patterns/trends and report in QASA meeting weekly for 4 weeks and then monthly thereafter. The QASA Committee will evaluate the effectiveness of the above plan and adjust the plan based on outcomes/trends identified.</td>
<td>7/12/11</td>
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During an interview with the Family Nurse Practitioner (FNP) on 06/16/11 at 10:45 a.m. he verified Resident #5 was ordered do not resuscitate when she was re-admitted to the facility.

During an interview with the Director of Nursing (DON) on 06/15/11 at 3:15 p.m. she stated she was unaware the Do Not Resuscitate (DNR) form and the Advance Directives/Medical Treatment Decisions Acknowledgment of Receipt form indicated the resident was do not resuscitate but the physician order sheet indicated full code. She verified the discrepancy had been in Resident #5's medical record since she was re-admitted on 04/20/11 and stated it should have been caught during medical record audits and corrected before now.

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