STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility failed to notify the physician of	F 157	F 157 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #74. Physician was notified on July 14, 2011, regarding resident #74 weight status. Director of Nursing (DON) and Staff Development Nurse (SDC) provided in service education for licensed nurses beginning July 19, 2011, regarding Policy and Procedure for notification of Physician for weight variances. 2. Current residents have the potential to be affected by the same alleged deficiency. DON, Assistant DON, and RN unit managers conducted an audit of current resident weights beginning July 21, 2011 to identify residents with weight variance and assure notification of Physician had occurred. Physician was notified regarding discrepancies identified and appropriate documentation was placed into the chart to support notification as necessary. SDC provided in service education beginning July 19, 2011, for licensed nurses, regarding Policy and Procedure for notification of Physician regarding weight variances. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: SDC provided in service education for licensed nurses beginning July 19, 2011, and new hires during orientation, regarding Policy and **" 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."**	8-11-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 8-5-11

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 157	Continued From page 1 significant weight loss for 1 of 3 sampled residents reviewed for nutrition. (Resident #74) The findings are: Resident #74 was admitted to the facility on 5/31/11 with diagnoses including multi infarct dementia, failure to thrive, status post gastrostomy tube (GT) placement, renal insufficiency, chronic anemia, atrial fibrillation and dysphagia. An admission minimum data set dated 6/7/11 assessed Resident #74 with short and long-term memory deficits, modified independence with daily decision making. Review of the Resident's care plan for enteral nutrition related to failure to thrive, updated 7/5/11 included the approach to notify the physician as indicated. Review of weight data in the medical record revealed Resident #74's weight on admission was 151.5#. On 6/8/11 his weight was 140.5 resulting in a 7.3% weight loss 9 days after admission. On 6/15/11 his weight was 141#. On 6/22/11 his weight was 132# which resulted in a 12.8% weight loss 23 days after admission. On 6/29/11 his weight increased to 136#, which resulted in an overall weight loss of 10.2% 30 days after admission. On 7/12/11 at 4:15 PM the consultant dietitian stated in interview that Resident #74 had several medical issues to address upon admission. After admission, his calories were increased via enteral nutrition and should have resulted in weight gain and an improvement in his lab values, but it did not. The consultant dietitian stated that she spoke to the nurse practitioner (NP) regarding the	F 157	Procedure for notification of Physician regarding weight variances. DON, RN unit managers and Dietary manager (DM) will review weights weekly ongoing, for residents identified with weight variances and assure documentation is present in chart regarding notification of Physician for weight variance. Physician will be notified regarding weight variance when identified. 4. Director of Nursing will analyze audits 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. **" 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 157	Continued From page 2 weight loss for Resident #74, but did not document a progress note. She stated that she did not speak to the doctor directly regarding the continued weight loss for Resident #74. On 7/13/11 at 1:30 PM an interview with the NP stated that she remembered having a conversation with the consultant dietitian on 6/13/11 regarding medication changes for Resident #74 due to abnormal lab values. His lab values were reviewed and physician orders were written to adjust his electrolytes and the weight loss would have also been affected by these adjustments to his electrolytes, but the weight loss was not the primary discussion. The NP further stated that if she had been made aware of the Resident's continued weight loss, this could have been addressed. On 7/14/11 at 3:32 PM an interview with the physician revealed that medication changes were made to adjust the Resident's electrolytes because of low lab values, but he did not remember anyone informing him of the Resident's weight loss. He stated that he expected to be informed immediately because changes should not just be made to respond to the labs, but his team would address the patient as a whole. He stated that he spoke to his NP and she was also not informed. On 7/14/11 at 4:00 PM, the assistant director of nursing stated that the physician should be notified with significant weight changes of 5% or more. She also stated that she reviewed the Resident's medical record and the physician's communication book and found no documentation that the physician was notified of	F 157		

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F 157	Continued From page 3 significant weight loss for Resident #74. She confirmed that she did not notify the physician of weight loss for Resident #74. On 7/14/11 at 4:38 PM, the DON stated that the physician should be notified with significant weight changes of 5% or more within 30 days or 10% or more within 6 months. She confirmed that she had not informed the physician that Resident #74 had significant weight loss.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to provide thickened liquids at a consistency appropriate for 1 of 1 sampled resident with swallowing problems. (Resident #74) The findings are: Resident #74 was admitted to the facility with diagnoses including multi infarct dementia, failure to thrive, status post gastrostomy tube (GT) placement and dysphagia with a high risk for aspiration pneumonia. An admission minimum set dated 6/7/11 assessed Resident #74 with	F 309		

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F 309	Continued From page 4 short and long-term cognitive deficits, modified independence with daily decision making, requiring extensive staff assistance with eating. Review of the Resident's care plan for failure to thrive, updated 7/5/11 revealed approaches to include providing an oral diet per order. On admission, Resident #74 received 100% of his nutrition via a GT. Resident #74 was referred for speech therapy (ST) services on 6/2/11 because of a complaint of being hungry. The ST treatment goals included, in part, treatment to reduce the risk of aspiration and trials of food by mouth. On 7/5/11 and 7/6/11, a physician's order was written to discontinue nothing by mouth for Resident #74 and he was placed on a puree diet with honey thickened liquids with swallowing precautions and to be fed by staff. An interview with the ST on 7/12/11 at 2:40 PM revealed that Resident #74 had progressed to a puree diet with honey thickened liquids eating 100% of his foods. She also stated that he still demonstrated signs and symptoms for aspiration risks with trials of nectar thickened liquids (NTL). On 7/13/11 from 9:10 AM to 9:30 AM during a continuous observation, Resident #74 was observed fed breakfast by the ST. He received and ate 100% of a pureed diet with honey thickened liquids to include grits, eggs, sausage and 240 ml of orange juice. A cooler of honey thickened liquids was stored at his bed side. On 7/13/11 from 2:00 PM to 2:15 PM, during a continuous observation, Resident #74 was observed fed lunch by nursing assistant #1. He received a pureed diet with nectar thick liquids (NTL) to include a hamburger with a relish plate,	F 309	F 309 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #74. Physician was notified on July 13, 2011 by the licensed nurse regarding that the resident did not receive the appropriate thickened liquid on his lunch tray. Orders were received to monitor resident for signs and symptoms of aspiration. Resident #74 did not exhibit signs and symptoms of aspiration. Director of Nursing provided a clarification "In House Communicator" to the dietary department on July 13, 2011 to provide honey thickened liquids on resident #74's meal trays. 2. Residents receiving thickened liquids have the potential to be affected by the same alleged deficiency. Director of Nursing (DON), Assistant DON, RN unit managers and Dietary Manager (DM) identified residents with orders for thickened liquids beginning July 19, 2011, to assure tray card and physician orders were accurate. Discrepancies identified were corrected at that time and Physician was notified. Staff Development Nurse (SDC) provided in service education beginning July 19, 2011 for licensed nurses and therapy staff regarding completion of "In House communicator" which will be reviewed by second staff member for accuracy prior to sending to dietary department. **" 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."**	8-11-11

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F 309	Continued From page 5 French fries, fruit cocktail and water. Resident #74 coughed twice at the end of his meal after drinking his water. His lunch tray card recorded his diet as pureed with NTL. On 7/13/11 at 2:30 PM an interview with the assistant dietary manager revealed that she received an "In-House Communicator" for a diet change dated 7/13/11 for Resident #74 which recorded "(symbol for change) diet to puree (sign for with) NTL" . She stated his diet was changed in the tray card computer tracking system after breakfast on 7/13/11. Review of the "In-House Communicator" revealed the diet was changed and signed by the ST on 7/13/11. On 7/13/11 at 2:32 PM interview with ST revealed that she wrote the diet change in error for Resident #74. She further clarified that she recorded the wrong resident's name on the diet change. The ST confirmed that Resident #74 was to receive a pureed diet with HTL. On 7/13/11 at 5:30 PM interview with the director of nursing confirmed that Resident #74 received NTL in error. She stated that the physician was contacted and an order had been received to monitor Resident #74 for signs or symptoms of aspiration.	F 309	3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Staff Development Nurse (SDC) provided in service education beginning July 19, 2011 for licensed nurses and therapy staff regarding completion of "In House communicator" which will be reviewed by second staff member for accuracy prior to sending to dietary department. New hires will receive in service during orientation. DON, ADON, RN Managers and Dietary Manager will review telephone orders daily Monday through Friday to identify residents with orders for thickened liquids. Dietary Manager will compare tray card to physician order to assure accuracy. Physician will be notified regarding discrepancies identified. 4. Director of Nursing and Dietary Manager will analyze audits 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.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	**" 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 312	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to provide nail care for 1 of 1 sampled resident dependent on staff for activities of daily living. (Resident #74) The findings are: Resident #74 was admitted to the facility with diagnoses including multi infarct dementia, cerebrovascular accident (stroke) and diabetes mellitus II. An admission minimum data set dated 6/7/11 assessed Resident #74 with short and long-term cognitive deficits, modified independence with daily decision making, and requiring extensive staff assistance with activities of daily living (ADLs) including personal hygiene. Review of the Resident's care plan for assistance with ADLs, dated 6/9/11, included approaches for staff to provide assistance personal hygiene. On 7/12/11 at 2:20 PM Resident #74's finger nails of the right hand were observed to extend approximately ½ inch beyond the nail bed with dark colored brownish debris underneath each nail. The nail of the index finger was jagged and broken. On 7/13/11 at 8:30 AM Resident #74's finger nails of both the right and left hand were clean except the thumb nail of the right hand; this nail had dark colored brownish debris underneath. All finger nails of both the right and left hands extended approximately ½ inch beyond the nail bed and the index finger of the right hand was jagged and broken. On 7/13/11 at 10:35 AM Resident #74 received a bed bath by nursing assistant #2 (NA #2). His finger nails on both the	F 312	F 312 Corrective action has been accomplished for alleged deficient practice in regards to Resident # 74. Resident received nail care on July 13, 2011. Staff Development nurse provided in service education beginning July 19, 2011, regarding Policy and Procedure for providing nail care to residents. Residents that are unable to carry out activities of daily living have the potential to be affected by the alleged deficient practice. DON/SDC/RN unit mangers assessed current residents nails to determine if nail care has been provided beginning July 19, 2011. Residents identified with long nails received nail care and refusals were documented in medical record. Monitors put into place to ensure alleged deficient practice does not recur include: SDC provided in service education beginning July 19, 2011 for nursing staff regarding *"Providing assistance for residents that are unable to carry out activities of daily living: grooming, nail care."* Licensed nurses perform weekly skin assessments, which include observation of nails. Admission assessments performed by the licensed nurse include observation of nails; residents identified with long nails will **" 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."**	8-11-11

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F 312	Continued From page 7 right and left hands were observed as previously described, additionally each nail had dark colored brownish debris underneath and the finger nails of the right hand were odorous. Resident #74 was not offered to have his fingernails cleaned or trimmed during the bed bath. On 7/13/11 at 10:55 AM NA #2 stated that she was finished giving Resident #74 his bed bath and he was getting ready to go to therapy. She had not noticed the condition of his nails. She confirmed that she should have cleaned his nails and informed his nurse that his nails needed to be trimmed. She further stated that nail care should be provided with showers and as needed. Resident #74 stated "Yes" when asked if he wanted his finger nails trimmed and cleaned. On 7/13/11 at 11:05 AM the director of nursing (DON) observed the fingernails of Resident #74 and confirmed that nail care was needed. The DON stated that nail care should be done with showers and as needed. She also stated that since Resident #74 was a diabetic and his nails were thick, she would prefer to have a licensed nurse trim his nails. She stated that nails were to be observed by nursing staff during care and during weekly head to toe skin checks. On 7/13/11 at 11:15 AM interview with licensed nurse #1 revealed that nails were checked during weekly skin checks, during showers and during nursing care. She further stated that she had not noticed the length of Resident #74's finger nails and she had not been informed that he needed his nails trimmed. A follow up interview with NA #2 on 7/13/11 at	F 312	have them trimmed or refusal will be notified in medical record. DON/or designee will begin audits on 7/25/11 of at least 3 skin assessments weekly x 4 weeks then 3 assessments monthly x 3 months to determine if residents identified with long nails have had nails trimmed or seen podiatrist. DON will identify any trends or patterns identified during audits and bring to QAA weekly x4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified. **" 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 312	Continued From page 8 6:00 PM revealed that she did not remember providing him with nail care on the days she provided care to him. On 7/14/11 at 12:42 PM nursing assistant #3 stated that she provided Resident #74 with bed baths. She confirmed that she did not offer nail care when she provided care to him, but that nail care should be provided as needed with baths/showers. On 7/14/11 at 2:23 PM, the staff development coordinator stated in an interview that she trained nursing staff to provide nail care when ADL care was done during bed baths, showers and as needed. She further stated that if nursing assistants felt like they did not have time to provide nail care during ADL care, the nurse should be informed so that the care could be given. Review of documentation of in-services during this interview revealed that the nursing assistants who provided care to Resident #74 received an in-service on 6/13/11 and 6/25/11 which included instruction that nail care and nail grooming was to be included during ADL care for residents.	F 312		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced	F 363		

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F 363	Continued From page 9 by: Based on observation, staff interview and the facility menu, the facility failed to follow the approved menu for a lunch meal. The findings are: On 7/13/11 at 12:10 PM, the lunch meal tray line was observed. The lunch menu for 7/13/11, signed and approved by the consultant dietitian, included a three ounce hamburger patty and two slices of cheese for cheese burgers. During the tray line, the dietary manager was observed to assist dietary staff #3 with plating hamburger patties and the assistant dietary manager assisted with tray set up. On 7/13/11 at 12:20 PM, the first cart with residents lunch meals was identified by the dietary manager as ready for delivery. Further observation revealed that 21 residents meals (11 puree diets, 6 mechanical soft diets and 5 regular diets) did not have cheese for the cheese burger. The dietary manager stated that he needed to verify the menu and after verification, he confirmed that cheese burgers were on the menu. On 7/13/11 at 12:21 PM, dietary staff #3 stated that he just forgot the cheese. On 7/13/11 at 12:22 PM the assistant dietary manager confirmed that she did not realize that cheese was not on the residents plate. She further stated that three slices of cheese were added during the preparation of thirty hamburger patties for residents on mechanical soft diets, but additional cheese should have been added during plating of the meal. On 7/13/11 at 12:35 PM, the dietary manager	F 363	F 363 1. Corrective action has been accomplished for the alleged deficient practice in regards to following approved menu. Dietary manager provided in service education beginning July 13, 2011, for dietary staff, regarding following menu as provided in order to meet the nutritional needs of the residents. 2. Current residents have the potential to be affected by the same alleged deficiency. Dietary manager and Assistant dietary manager began to observe tray lines daily on July 13, 2011, to assure accuracy of trays according to menu provided. Discrepancies were corrected when identified. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Dietary manager provided in service education beginning July 13, 2011, for dietary staff, regarding following menu as provided in order to meet the nutritional needs of the residents. Dietary manager and Assistant Dietary manager will observe tray lines daily for 2 weeks then three times per week for 2 weeks then weekly ongoing to assure accuracy of trays according to menu provided. Discrepancies will be corrected when identified. 4. Dietary manager will analyze data obtained during tray line observation for **" 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."**	8-11-11

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F 363	Continued From page 10 confirmed that cheese should have been provided with the hamburgers and stated that the assistant dietary manager was responsible for ensuring that all items were ready for the start of the tray line.	F 363	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.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to apply hair and beard restraints for five of eight dietary staff. The findings are: The facility policy, Food Handling Practices, dated March 2009, recorded in part, "Practice good personal hygiene, restrain hair and cover beards appropriately." A kitchen observation was conducted and revealed the following concerns with hair and beard restraints. a. Dietary Staff #1 was observed on 7/11/11 at 9:58 AM cutting turkey for the lunch meal. On 7/13/11 at 12:01 PM, dietary staff #1 stated that	F 371	**" 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."**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 07/14/2011

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F 371	Continued From page 11 she prepared chicken livers and prepped the hamburgers that day for the lunch meal. During each observation she wore a hair net that did not restrain the front, right or left sides of her hair. Additionally, her hair net was observed with a large hole on the right side. Dietary staff #1 confirmed in interview that she knew to wear a hair net that covered all of her hair. b. Dietary staff #2 was observed on 7/11/11 at 10:00 AM washing dirty dishes and storing clean dishes. On 7/13/11 at 11:55 AM Dietary staff #2 was observed pouring cups of water for the lunch meal and at 12:16 PM he was observed to plate soup for a resident. During each observation he wore a hair net that did not restrain hair that hung down to his shoulders. Dietary staff #2 was also observed with long facial hair on his chin and no beard restraint. Dietary staff #2 stated on 7/13/11 at 12:43 PM that he usually wore a hair net to cover all of his hair but was just rushing and did not check it. He also stated that he had not been trained to cover his facial hair. c. Dietary staff #3 was observed on 7/11/11 at 10:07 AM preparing potatoes for the lunch meal. On 7/13/11 at 12:00 PM he plated food for the lunch meal for residents. During both observations, he had short facial hair above his upper lip and on his chin, but he did not have on a beard restraint. d. On 7/13/11 at 12:14 PM, dietary staff #4 was observed setting up lunch meal trays for lunch. She wore a hair net that did not restrain the front section of her hair. She confirmed in an interview at 12:45 PM that she should wear a hair net to cover all of her hair. e. On 7/13/11 at 12:18 PM, the assistant dietary manager was observed on the lunch tray line plating soup for residents. She wore a hair net	F 371	F 371 1. Corrective action has been accomplished for the alleged deficient practice in regards to applying hair and beard restraints in the dietary department. Staff identified during survey was instructed to apply or replace hair and beard restraint in order to promote sanitary conditions in the dietary department. Dietary Manager (DM) provided in service education, beginning July 13, 2011, for dietary staff, regarding use of hairnets and beard restraints to promote sanitary conditions in the dietary department. 2. Current residents have the potential to be affected by the same alleged deficiency. Staff identified during survey was instructed to apply or replace hair and beard restraint in order to promote sanitary conditions in the dietary department. DM provided in service education beginning July 13, 2011, regarding use of hairnets and beard restraints to promote sanitary conditions in the dietary department. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: DM provided in service education beginning July 13, 2011, regarding use of hair nets and beard restraints to promote sanitary conditions in the dietary department. DM and/or Assistant DM will observe dietary staff daily for use of hairnets and beard restraints. **" 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."**	8-11-11

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F 371	Continued From page 12 that did not restrain the back section of her hair. The assistant dietary manager stated in an interview on 7/13/11 at 12:40 PM that all hair should be covered with a hair net and that she tried to monitor for this. She confirmed that she had noticed that the hair of dietary staff #2 had grown and his hair net did not cover all of his hair, but she had not addressed this. On 7/13/11 at 12:35 PM, the dietary manager confirmed in an interview that hair nets should cover all of the hair. He further stated that he had not instructed staff with facial hair to wear beard restraints.	F 371	Discrepancies will be corrected when identified. 4. Dietary manger will analyze data obtained from 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.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**" 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 431	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to store three unopened insulin vials in the refrigerator until opened. The findings are: Observations of the 400 hall medication cart on 07/12/11 at 2:50 PM, revealed one (1) unopened Humalog 100 units/ml insulin vial and one (1) unopened vial of Novolin Regular 100 units/ml insulin. The Humalog and Novolin insulin vials were labeled "Refrigerate until opened." On 07/12/11 at 2:54 PM an interview was conducted with a Licensed Nurse (LN) #1. During this interview LN #1 stated that she administered medications from the 400 hall medication cart to residents and was not aware that the insulin needed to be refrigerated until opened. LN #1 was unable to specify how long the unopened vial of insulin had been stored on the medication cart. Observations of the 300 hall medication cart on	F 431	F 431 1. Corrective action has been accomplished for the alleged deficient practice in regards to storage of unopened insulin. Insulin identified in medication cart unopened was discarded on 7/12/11. 2. Residents with orders for insulin have the potential to be affected by the alleged deficient practice. SDC provided in service education for licensed nurses beginning July 19, 2011 regarding *"Policy and Procedure: Dating, labeling and storage of medications and expiration dates for medications once opened."* DON/SDC/RN supervisor will conduct daily audits of medication carts to assure medications are properly labeled, stored and discarded according to policy and procedure. Discrepancies identified will be corrected and reviewed in QAA weekly x 4 weeks then monthly. 3. Monitors put into place to ensure the alleged deficient practice does not recur include: SDC provided in service education for licensed nurses beginning 7/19/11 regarding *"Policy and Procedure: Dating, labeling and storage of medications and expiration dates for medications once opened."* DON/SDC/RN supervisor **" 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."**	8-11-11

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F 431	Continued From page 14 07/12/11 at 3:15PM revealed one (1) unopened vial of Humalog 100 units/ml insulin which was labeled "Refrigerate until opened." On 07/12/11 at 3:17 PM Licensed Nurse (LN) #2 was interviewed. LN #2 stated that she administered medications from the 300 hall medication cart and confirmed that the vial of Insulin stored on the cart was unopened. LN #2 stated that the insulin vial should be refrigerated until opened. LN #2 was unable to specify how long the unopened vial of insulin had been stored on the medication cart. On 07/13/11 at 2:16 PM the Director of Nursing (DON) was interviewed. The DON stated that insulin vials are labeled to refrigerate until opened and that unopened vials of insulin should not be stored on medication carts.	F 431	will conduct daily audits of medication carts to assure medications are properly labeled, stored and discarded according to policy and procedure. Discrepancies identified will be corrected and reviewed in QAA weekly x 4 weeks then monthly. 4. DON/SDC will identify any trends or patterns identified during audits and bring to weekly QAA x 4 weeks then monthly. QAA committee to evaluate the effectiveness of the plan based on trends identified and adjusts the plan if negative trends identified. **" 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."**	