PRINTED: 10/19/2011 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION 3 1 7011	(X3) DATE SI COMPLE	
		345262	B. WI	VG		10/	07/2011
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA!	В/НЕ		1	REET ADDRESS, CITY, STATE, ZIP CODE (300 DON JUAN ROAD HERTFORD, NC 27944	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	maintenance services sanitary, orderly, and  This REQUIREMENT by: Based on observation resident and interview provide maintenance smaintain a clean, orderinterior.  Findings include:  1) On 10/04/2011 at 1 interview was conduct room 208 (window bedwas noted the footboar was hanging down on observation of the foot no screws or bolts attaside to the bed. The remissing screws/bolts. of this or the additional problem and/or enviror the footboar and/or envirored the footboar and/or envirored the footboar and/or envirored the footboard and for the resident on 10/05/2011 at 8:40 9:00 a.m. The footboard days to be still hanging one side of the resident on 10/06/2011 at 10:00 facility's maintenance remade. The facility was	de housekeeping and necessary to maintain a comfortable interior.  is not met as evidenced as, record reviews, staff and is the facility failed to services necessary to rrly, and comfortable  10:43 a.m. a resident ed with resident # 21 in ed.). During the interview it rd on the resident 's bed one side. Further board revealed there were inching the footboard to that esident was unaware of the linding noted below as a mental issue.  If the footboard were made a.m. and 10/06/2011 at rd was observed on both is without screws or bolts on it # 21 's bed.  In a.m. a review of the equest procedure was		25.	"Preparation and /or executation of correction does not constitute admit agreement by the provider of the traileged or conclusions set forthin the deficiencies. The plan of correction and/or executed solely because it is provisions of federal and state law.  1. Corrective action has been a related to the alleged deficient regards to resident # 21 foot b replaced and foot board secure on 10/07/11. Ceiling repair corroom 208 on 10/27. Resident along the bed closest to door of gouge was repaired and painted Resident room 304 wall behin repaired and painted on 10/24 installed on headboard to previous damage. Grab bar in ladies shattached to wall on 10/6/2011  2. Facility residents have the effected by the same alleged dipractice. Staff re-educated on to report repairs need to reside or building repairs. Mainten and Administrator completed on 10/19 of all resident rooms corrections were identified prischeduled.	ssion or ruth of the facts he statement of his prepared required by the required by the recomplished practice in oard hardware ely attached inpleted on room 301 wall rack with a red on 10/27/11. Bumper rent father wall rower securely rent equipment the procedure ent equipment ance Director a 100% audit. Needed	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the

10/28/201

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345262	B. WA	G_		10/0	7/2011
	ROVIDER OR SUPPLIER	В/НЕ		1	REET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
F 253	the building and residinurse's station stated needing maintenance out a maintenance request station and give the manager so he knew and repair it. The mai was observed at the maintenance request the binder for staff acc.  On 10/06/2011 at 10:1 facility's maintenance marmaintenance process that when a maintenance that when a maintenance documented he would request slip and would request slip and would maintenance manager showing documentation deferred maintenance manager maintenance manager maintenance manager maintenance manager maintenance manager has no maintenance reshowing knowledge of 21's bed (footboard). manager stated he had	g and g needed maintenance to ent equipment. Staff at the d when they found an issue and or repair they would fill quest located in the binder located at the nurse ' request to the maintenance about the problem/issue intenance request binder turse 's station. Blank slips were observed to be in tess and documentation.  10 a.m. an interview with the emanager was conducted. In ager confirmed the moted above and stated ince request was receive the maintenance. If keep it on file. The instated he kept the files in for current, pending, and as well as completed.  We of the maintenance and with the facility 's in the facility 's acknowledged the facility equests or documentation in need to repair resident # The facility 's maintenance in oprior knowledge that is in need of repair and	F	253	3. Systemic measures implement ensure the same alleged deficient does not recur include: Staff recethe procedure to report issues with equipment or repairs needed on the plant. Housekeeping department maintenance repair request on the housekeeping cart. Staff are to reneeds to the Maintenance Director repair request form. Department will conduct rounds daily Monda Friday, to identify needed repairs repair request Monday thru Friday the Interdisciplinary Team Meeting repair needs will be prioritized as scheduled for completion.  4. The repair request will also be monthly by the Maintenance Director Administrator to analyze for trenewill be reported to the Quality As and Assurance Committee month Quality Assessment and Assurance Assurance Committee will evaluate effectiveness of the plan based on identified and develop and implemental distributional interventions as needed continued compliance.	t practice ducated on the resident he physical will keep he eport repair or using the Managers y thru and subming during ng. The had reviewed ector and ds. Result is sessment by x 3 The ce and te the a trends ment had to ensure	

	OF DEFICIENCIES FORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING  B. WING	***************************************			
		345262	B. WING		10	/07/2011	
	ROVIDER OR SUPPLIER	AB/HE	130	ET ADDRESS, CITY, STATE, ZIP CO 10 DON JUAN ROAD RTFORD, NC 27944	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 253	was conducted with	ge 2  0:43 a.m. a resident interview resident # 21. During the erved that the ceiling above	F 253				
	the resident's bed I stains on it from the running half the leng observed that some was missing cracked repair to the residen have been made at additional dark brow and around the repair to the repair to the resident have been made at additional dark brow and around the repair to its from the repair to the resident have been made at additional dark brow and around the repair to the repair to the resident have been made at a different had been the repair to the	had multiple dark brown wall outward several feet and of the bed. It was also of the ceiling texturing paint d/peeling in other areas. A t's ceiling was observed to some time in the past and on stain lines had gone into hired area. The resident had the dark lines in the ceiling or					
	were made on 10/05 10/06/2011 at 9:00 a observed on both da brown stain lines an	s of the resident 's ceiling 5/2011 at 8:40 a.m. and a.m. The ceiling was ays to still have the dark d the cracked/peeling e resident # 21 's bed.					
	facility's maintenance made. Staff at the r they found an issue					The state of the s	
	request binder and of maintenance manage problem/issue and request binder was station. Blank main	st located in the maintenance give the request to the ger so he knew about the epair it. The maintenance observed at the nurse 's tenance request slips were e binder for staff access and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345262	B. WN	G		10/0	7/2011
	ROVIDER OR SUPPLIER	В/НЕ		130	EET ADDRESS, CITY, STATE, ZIP CODE 00 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 253	facility's maintenance. The maintenance maintenance process that when a maintenan documented he would request slip and would maintenance manage showing documentating deferred maintenance maintenance.  On 10/06/2011 a revier requests (slips) was maintenance manage maintenance manage maintenance request resident #1's room. manager acknowledg maintenance requests maintenance had bee above resident #21's maintenance manage leak in the roof above 21's bed (could not roof had been initially initial repair the ceiling and a second repair to (date unknown). The stated that he had no or second repairs and complete a second re resident #21's bed. manager stated he had ceiling texturing then process.	10 a.m. an interview with the e manager was conducted. In ager confirmed the noted above and stated note request was discrete the maintenance of keep it on file. The restated he kept the files on for current, pending, and e as well as completed ew of the maintenance nade with the facility 's r. There was no slip for the ceiling in The facility 's maintenance ed the facility has no a or documentation showing in conducted on the ceiling	F	253			

Facility ID: 943003

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		345262	B. WNG		10/0	7/2011
	NOVIDER OR SUPPLIER	B/HE	130	ET ADDRESS, CITY, STATE, ZIP CODE 00 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 253	made of the women' the facility's nurse's observation the toilet was attached but loos could be easily move indicating it was not a wall.  A further observation 9:40 a.m. The toilet g still be loosely attached be easily moved up a On 10/06/2011 at 10: facility's maintenance made. Staff at the nut they found an issue the maintenance request request binder and gimaintenance manage problem/issue and repreduest binder was obstation. Blank mainten observed to be in the documentation.  On 10/06/2011 at 10: facility's maintenance manage maintenance maintenance maintenance maintenance maintenance maintenance maintenance maintenance maintenance manage in a maintenance manage maintenance manage maintenance manage maintenance manage manag	8:45 a.m. observations were s shower room across from a station. During the grab bar in the shower room se on the wall. The bar d ½ - 1 inch up and down a solid attachment to the was made on 10/06/2011 at grab bar was observed to sed to the wall and could still and down.  200 a.m. a review of the request procedure was rise station stated when hely would fill out a located in the maintenance we the request to the riso he knew about the pair it. The maintenance observed at the nurse signal is not a manager was conducted. In ager confirmed the moted above and stated ince request was a receive the maintenance of keep it on file. The ristated he kept the files on for current, pending, and	F 253			

F 253  Continued From page 5  On 10/06/2011 a review of the maintenance requests (slips) was made with the facility 's maintenance request/repair slip for the toilet grab bar located in the women 's shower room across from the nurse 's station. The facility 's maintenance manager acknowledged the facility had no maintenance requests/slips or documentation showing knowledge of or need to		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE:			
BRIAN CENTER HEALTH & REHAB/HE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 253  Continued From page 5  On 10/06/2011 a review of the maintenance requests (slips) was made with the facility's maintenance request/repair slip for the toilet grab bar located in the women's shower room across from the nurse's station. The facility's maintenance manager acknowledged the facility had no maintenance requests/slips or documentation showing knowledge of or need to			345262	B. WNG		10/0	07/2011
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 253  Continued From page 5  On 10/06/2011 a review of the maintenance requests (slips) was made with the facility 's maintenance request/repair slip for the toilet grab bar located in the women 's shower room across from the nurse 's station. The facility 's maintenance manager acknowledged the facility had no maintenance requests/slips or documentation showing knowledge of or need to			В/НЕ		1300 DON JUAN ROAD		
On 10/06/2011 a review of the maintenance requests (slips) was made with the facility 's maintenance manager. There was no maintenance request/repair slip for the toilet grab bar located in the women 's shower room across from the nurse 's station. The facility 's maintenance manager acknowledged the facility had no maintenance requests/slips or documentation showing knowledge of or need to	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION
repair the toilet grab bar in the women 's shower room. The facility's maintenance manager stated he had no prior knowledge that the toilet grab bar was in need of repair and stated that the toilet area of the shower room would be closed and he would initiate repairs immediately.  4) On 10/05/2011 at 8:47 a.m. an observation was made of resident room 301. During the observation it was noted that the wall running along the bed closest to the door appeared to be cracked with a gouge in the wall and had paint peeling off the area. The area was approximately 4 foot from the floor.  A further observation was made on 10/06/2011 at 9:42 a.m. The wall was observed to still have the gouged area where the paint was peeling and appeared to be cracked.  On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. The facility was found to have a procedure for detecting and reporting/documenting needed maintenance to the building and resident equipment. Staff at the nurse's station stated when they found an issue	f 253	On 10/06/2011 a revirequests (slips) was a maintenance manage maintenance request bar located in the work from the nurse's star maintenance manage had no maintenance documentation showing repair the toilet grab from. The facility's stated he had no prior grab bar was in need toilet area of the show and he would initiate.  4) On 10/05/2011 at was made of resident observation it was not along the bed closest cracked with a gouge peeling off the area. A foot from the floor.  A further observation 9:42 a.m. The wall we gouged area where the appeared to be cracked. On 10/06/2011 at 10:10 facility's maintenance made. The facility we procedure for detection reporting/documenting the building and resident procedure for detection reporting/documenting the building and resident procedure for detections.	ew of the maintenance made with the facility 's er. There was no /repair slip for the toilet grab men's shower room across tion. The facility 's er acknowledged the facility requests/slips or ing knowledge of or need to par in the women's shower maintenance manager or knowledge that the toilet of repair and stated that the over room would be closed repairs immediately.  8:47 a.m. an observation to room 301. During the ted that the wall running to to the door appeared to be in the wall and had paint. The area was approximately was made on 10/06/2011 at the paint was peeling and the paint was peeling and ed.  00 a.m. a review of the request procedure was as found to have a reg and g needed maintenance to lent equipment. Staff at the	F 253			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		345262	B. WIN	G		10/0	7/2011
	OVIDER OR SUPPLIER	\B/HE		1	EET ADDRESS, CITY, STATE, ZIP CODE 300 DON JUAN ROAD IERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 253	out a maintenance re maintenance request s station and give the manager so he knew and repair it. The may was observed at the maintenance request the binder for staff activity is maintenance maintenance process that when a maintenance maintenance documented he woul request slip and wou maintenance manage showing documentat	e and or repair they would fill equest located in the to binder located at the nurse be request to the maintenance about the problem/issue aintenance request binder nurse be station. Blank at slips were observed to be in cocess and documentation.	F	253			
	requests (slips) was maintenance manager maintenance request needing to be condumaintenance manager manager acknowledgrequests/slips or other knowledge of or need door bed in room 30 manager could not strong wall would be conducted.	Urepair slip for any work cted in room 301 in the er's files. The maintenance ged he had no maintenance er documentation showing d to repair the wall behind the 1. The maintenance tate when the repair to the cted.  8:50 a.m. an observations				The day of the control of the contro	
	was made of residen	t room 304. During the			cility ID: 943003	f continuation she	at Page 7 of 20

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345262 B. WING 1	07/2011
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE  STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 Continued From page 7 observation it was noted that the wall behind the headboard of the door bed had been gouged by the resident's headboard being hit against the wall. The back of the headboard had pleces of wall paint on it where it had been hit against the wall. The gouge in the wall appeared to be 5 inches square.  A further observation was made on 10/06/2011. The bed was observed against the wall where the gouge in the wall was. There was no device found on the headboard to keep it from hitting the wall causing damage to the wall.  On 10/06/2011 at 10:00 a.m. a review of the facility's maintenance request procedure was made. The facility was found to have a procedure for detecting and reporting/documenting needed maintenance to the building and resident equipment. Staff at the nurse's station stated when they found an issue needing maintenance and or repair they would fill out a maintenance request located in the maintenance request bloder located at the nurse's station and give the request to the maintenance manager so he knew about the problem/issue and repair it. The maintenance request blinder was observed at the nurse 's station. Blank maintenance request slips were observed to be in the binder for staff access and documentation.  On 10/06/2011 at 10:10 a.m. an interview with the facility's maintenance manager was conducted. The maintenance manager confirmed the maintenance request slip and would keep it on file. The	

Facility ID: 943003

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	ULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED		
		345262	B. WNG_		10/07	//2011
	OVIDER OR SUPPLIER	IAB/HE	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279 SS=D	maintenance mana showing documents deferred maintenance.  On 10/06/2011 a rerequests (slips) was maintenance mana maintenance requested wall behind the hear oom 304 in the maintenance redocumentation shorepair the wall behind in room 304. The root state when the conducted. 483.20(d), 483.20(f) COMPREHENSIVE A facility must use to develop, review comprehensive plate the develop of the facility must deplan for each reside objectives and time medical, nursing, aneeds that are identally assessment.  The care plan must to be furnished to a highest practicable psychosocial well-be §483.25; and any series.	ger stated he kept the files ation for current, pending, and he as well as completed eview of the maintenance is made with the facility's ger. There was no st/repair slip for the gouged adboard of the door bed in hintenance manager's files. In an ager acknowledged he had equests/slips or other wing knowledge of or need to had the door bed's headboard maintenance manager could repair to the wall would be ex)(1) DEVELOP E CARE PLANS	F 27	"Preparation and /or executar correction does not constitute ad agreement by the provider of the alleged or conclusions set forth in deficiencies. The plan of correct and/or executed solely because it provisions of federal and state la 1. Corrective action has been related to the alleged deficiencies regards to resident #40. A corrective action #40.	mission or e truth of the facts in the statement of ion is prepared is required by the w."  en accomplishe ent practice in care plan for d and validated ied on the care at # 97 no long ective action fo mplished. A ca ed and  e potential to b I deficient ary Team (IDT rehensive lans are in plac I with the Care plans will ent to meet the been identifie	e ed ed ee

Event ID: 48RS11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345262	8. WNG		10/07/2011
	OVIDER OR SUPPLIER	HAB/HE	1	REET ADDRESS, CITY, STATE, ZIP CODE 300 DON JUAN ROAD HERTFORD, NC 27944	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	JLD BE COMPLETION
F 279	due to the resident §483.10, including under §483.10(b).  This REQUIREME by: Based on staff intracility failed to develop a care plate 1 (Resident #40) of failed to develop a (Resident #26) of 1. Resident #26) of 1. Resident #40 vo 07/27/11 and was Diagnoses include (ESRD), hemo-dia	it's exercise of rights under g the right to refuse treatment	F 279	3. Systemic Measures put into ensure the same alleged deficie does not recur include: Interdisteam was re-educated on 10/14/Ausley, Regional Care Manage Coordinator regarding the proceeding the results of the comprehensive to develop, review and revise the comprehensive plan of care. The Care Management Director /des review 2 resident assessments we scheduled for a Care Plan Meetic comprehensive care plans are in x4 weeks and 4 residents month months. Results of the reviews discussed during the Interdiscip Meeting weekly times 4 weeks measures will be implemented a determined by the Interdisciplin	nt practice ciplinary 'I I by Lori ment ess of using e assessment e resident's e Resident ignee will tho are ng to ensure nplemented ly x2 will be linary Team Corrective s
	Set) assessment, Resident #40 had problems; was ab needed extensive living except for e incontinent of bow dialysis. Review assessment, date #40 was on dialys Review of the res there was no care	ident's medical record revealed plan for dialysis.  ility's contract with the agency		4. The Resident Care Director at Administrator will analyze the recare plan reviews for trends. Responsed to the Quality Assessment Assurance Committee monthly Quality Assessment and Assurant Assurance Committee will evaluate effectiveness of the plan based of identified and develop and imple additional interventions as needed continued compliance.	esults of the sults will be ent and a 3. The acc and ate the artends ement
	providing dialysis	for Resident #40 revealed a			11/04/2011

345282 B. WNG 10/0	7/2011
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE  STREET ADDRESS, CITY, STATE, ZIP CODE  1300 DON JUAN ROAD  HERTFORD, NC 27944	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 279 Continued From page 10 requirement for the facility was to have a care plan for dialysls.  An interview, on 10/06/11 at 3:32 PM, was conducted with MDS Nurse #1. MDS Nurse #1 reviewed the care plan for Resident #40 and was unable to locate the care plan for dialysls. She indicated she was not sure why the care plan was not there.  An interview, on 10/07/11 at 8:30 AM, was conducted with MDS Nurse #2. MDS Nurse #2 relayed she was sure she had completed a care plan for dialysls for Resident #40. She indicated she had reviewed the present record and the records for the resident's admission on 08/13/11 and was not able to locate the care plan for dialysis.  An interview, on 10/07/11 at 8:45 AM, was conducted with the Director of Nursing (DON). The DON relayed her expectation was that a care plan should have been in the resident's medical record.  2. Resident #97 was admitted to the facility on 08/10/11. Diagnoses included cerebral vascular accident, left side hemiplegia, hypertension, and coronary artery disease.  Review of the admission MDS (Minimum Data Set) assessment, dated 08/18/11, revealed the resident was moderately impaired cognitively and needed extensive assistance for activities of daily living. The MDS section concerning discharge planning was reviewed and indicated the resident want to talk to someone regarding the possibility of returning to the community.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET		
		345262	B. WING		10	/07/2011
	OVIDER OR SUPPLIER	HAB/HE	s	TREET ADDRESS, CITY, STATE, ZIP C 1300 DON JUAN ROAD HERTFORD, NC 27944	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From pa	age 11	F 27	79		
	summary, dated 00 the resident being was identified. The indicated the family would be able to return to the summary also not be able to return to help hin anticipation of this the facility would pure Review of the residence of the return to the correct or the correct of the residence of the return to the correct or the correct of the residence	a (Care Area Assessment) 8/20/11, revealed the area for able to return to the community enarrative of the CAA y's desire was the resident eturn home to the community. Indicated the resident would remain home alone; and, was occupational and speech reach his highest potential in goal. The summary indicated roceed to care plan.  Ident's medical record plan for the resident to be able mmunity.  0/06/11 at 3:32 PM, was DS Nurse #1. She indicated the by was the person who would be return to the community care				
	conducted with the would be the staff plan for the reside The SW stated the be able to go hom sure why the care community had not An interview, on 1 conducted with the	0/06/11 at 4:15 PM, was a SW and she confirmed she member to complete the care into return to the community. It is family desired the resident to early she indicated she was not plan for returning to the into been completed.  0/07/11 at 8:45 AM, was a Director of Nursing (DON).				
	The DON relayed care plan should he medical record.	her expectation was that the nave been in the resident's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345262	B. WN	G		10/0	7/2011
	OVIDER OR SUPPLIER	АВ/НЕ	•	1300 DC	DDRESS, CITY, STATE, ZIP CODE DN JUAN ROAD ORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 279	Continued From pag	ge 12	F	279			
	O5/26/11 and had di Mellitus and Hyperte The most recent Mir Assessment (Signifi showed that the resi could see large print newspapers and bot the resident had no The Care Area Asse 09/09/11 read: "Re vision, unable to rea needs to see eye do scheduled for 10/18/ associated with impa	nimum Data Set (MDS) cant Change) dated 09/0211 dent had impaired vision, i but not regular print in oks. The MDS showed that corrective lenses.  Assment (CAA) dated sident reports impaired d news print. Reports that he octor. In house eye exams 11. Care plan risks aired vision. " Tent's Care Plan showed no to the resident's impaired d in an interview on 10/05/11					
	vision for Resident#	e was not a Care Plan for 26 and that she must have e stated that she would do a			en de la companya de		·
	Director of Nursing, the MDS and CAAs identify problems and care plan or not to castated that if the deci	he Administrator and the he Administrator stated that were part of the process to d to make the decision to are plan. The Administrator ision was made to care plan e plan should have been					

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE	יטי
		345262	B. WING		10/07	//2011
NAME OF PR	OVIDER OR SUPPLIER	***************************************	1	EET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B/HE	l	300 DON JUAN ROAD		
			<u> </u>	IERTFORD, NC 27944	ECTION	//65
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	Continued From pag	e 13	F 279	F329		
F 329 SS=E	developed. 483.25(I) DRUG RECUNNECESSARY DE Each resident's drug unnecessary drugs. drug when used in eduplicate therapy); o	PAGENTAL SERVICES FROM STATES FROM STATES FROM PROPERTY OF THE PROPERTY OF T	F 329	"Preparation and /or executation of correction does not constitute admagreement by the provider of the talleged or conclusions set forthin talleged or conclusions of correction and/or executed solely because it is provisions of federal and state law.	ission or ruth of the facts he statement of n is prepared required by the	
without adequate me		nitoring; or without adequate e; or in the presence of		1.Corrective action has been a related to the alleged deficien	t practice in	
	adverse consequences which indicate the dose			regards to resident #74, #80 a	nd #82	
	should be reduced o	r discontinued; or any		On 10/6/2011 the physician for	or resident #74	
	resident, the facility who have not used a given these drugs ur therapy is necessary as diagnosed and do record; and resident drugs receive gradule behavioral interventi	nensive assessment of a must ensure that residents intipsychotic drugs are not alless antipsychotic drug to treat a specific condition ocumented in the clinical s who use antipsychotic al dose reductions, and		was notified by phone. Clarification orders for Multivitamin and Screeived. Physician ordered a Metabolic Panel and Magnesisthis time. Results were obtained notified, and a copy of the resistant of the medical record. No adphysician orders were received the lab work. Nurse #1 was extregarding questioning abnorm on medication administration comparing those orders to the physician order in the medical Physician was notified residen Depakote level was not obtain 9/28/11. A Depakote level was and obtained 10/6/11. Physician	enekot were Basic um level at ed, physician ults were put ditional d as a result of ducated al orders noted record and original record. t # 80's ed as ordered s re-ordered	
-	by: Based on record reinterviews the facility medications as order monitor a medication ordered by the phys	T is not met as evidenced view and staff and physician valued to administer 2 red by the physician, failed to by not drawing lab work as ician and failed to monitor ent taking anti-anxiety		and obtained 10/6/11. Physicinotified of the results on 10/7/2 orders received. The results of level were placed in the medical Nurse #3 was re-educated regatranscription and the process for labs. Resident #82 behavior makes the sheet for anti-anxiety therapy when identified.	2011. No new the Depakote al record. rding order or ordering onitoring	

Facility ID: 943003

CENTERO STATE PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ARE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTIO	
345262 B. WING 10/07/2011	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1300 DON JUAN ROAD  HERTFORD, NC 27944	
COUNTRIES II AN OF CORRECTION (X5)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S POAR OF CONTROL OF COMPLETE	
F 329 Continued From page 14 medications for 3 of 10 sampled residents whose medications were reviewed (Residents #74, 80 and 82).  The findings include:  Resident #74 was re-admitted to the facility on 08/24/11 and had diagnoses including Dementia, Diabetes Mellitus, Stage IV Kidney Disease and Constipation.  1a. Review of the admission orders dated 08/24/11 revealed an order for MVI (multiple vitamin) 1 tab P 0 tym outh) daily. Review of the Medication Administration Record (MAR) for august 2011 revealed that the MVI was given once a day as ordered. On 10/05/11 a review of the September 2011 monthly physician's orders revealed an entry dated 08/24/11 that read: "(Multiple Vitamin-Minerals) 1 table ty mouth (PO) QID. Mouth (PO) QID. The monthly orders had been signed by the resident's physician. The MAR for September and October 2011 showed an entry that read: "(Multiple Vitamin-Minerals) 1 Tablet by mouth (PO) QID. The MAR for September and October 2011 showed an entry that read: "(Multiple Vitamin-Minerals) 1 Tablet by mouth (PO) QID. The MAR for September and October 2011 showed that the medication had been given 4 times a day.  During an interview with the Director of Nursing (DON) on 10/05/11 at 3:30 PM, the DON was observed to review the resident's medical record and stated that on the admission orders the MVI was ordered once a day. The DON stated that on the September monthly physician's orders and the September monthly physician's orders and the September monthly physician's orders and the September monthly physician's orders the MVI was ordered once a day. The DON stated that on the September monthly physician's orders the MVI was ordered once a day. The DON stated that on the September monthly physician's orders the MVI was ordered once a day. The DON stated that on the September monthly physician's orders the MVI was ordered once a day. The DON stated that on the September monthly physician's orders the MVI was ordered once a day. The DON stated that on	

CENTERS FOR MEDICARE & F STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SUF COMPLETI	
		345262	B. WING		10/0	7/2011
	OVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP COI 300 DON JUAN ROAD HERTFORD, NC 27944	DE	
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	4:30 PM that she ha physician and that h MVI to be given once chemistry panel and DON stated that the signed the orders be orders were.  The DON stated in a 8:45 AM that the physician and the orders were the month the order computer by the waste the ward clerk must the orders into the continuous find anywhere in medications were on The DON stated that ward clerk entering that now a Register The DON stated that new to them and the used to the way he The DON stated that the twice a day but new Nurse #1 stated in 9:00 AM that the recissues and that she the MVI but that she medication ordered.  The resident's Phon 10/06/11 at 9:00 be given once a day have been a typo (	d spoken with the resident's e changed the order for the e a day and ordered a a magnesium level. The physician told her that he at did not recall what the an interview on 10/06/11 at sysician's orders and MAR for andwritten and at the end of s were entered into the rd clerk. The DON stated that have made an error in putting computer because she could at the chart that the rdered as printed on the MAR. At she had an issue with a the medication orders and ed Nurse was in that position. At the admitting physician was at the staff were still getting ordered some medications. At she had seen MVI ordered er four times a day.  an interview on 10/06/11 at sident had some wound ed did not question the order for e had never seen this	F 329	3. Systemic Measures pensure the same alleged does not recur include: admission/readmission to the (IDT) Interdiscipl Meeting, Monday thru Fare Director of Nursing validate Physician order into the electronic recorn The physician orders for be reviewed. The Direct Nursing/designee will be book to the IDT meeting be reviewed for notation validation of a lab requing Results of labs will also the IDT meeting to ensuorders were carried thru notification as ordered. will conduct random au order transcription, data monitoring and initiation monitoring sheets as incominimum 10 new or characteristic of the implemented as determined as determined the IDT.	deficient practice New records will be take inary Team Friday for review. Idesignee will s have been entered d system accurately r lab monitoring wi tor of ring the facility lab g. The lab orders wi n in the lab book an sition completion. be reviewed during me the previous lab with physician The DON/designe dits of physician entry, lab n of behavior dicated for a anged physician s, then monthly x 3 ngs will be addresse the audits will be 4 weeks and month he Interdisciplinary nal interventions w	l ll d g e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345262		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WIN	G		10/07/2011		
	OVIDER OR SUPPLIER	AB/HE	STREET ADDRESS, CITY, STATE, ZIP CODE  1300 DON JUAN ROAD  HERTFORD, NC 27944				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		(X5) COMPLETION DATE
F 329	given four times a d were giving it so she correct.  In an interview with DON on 10/07/11 at that the procedure v nurses to check the against the new MA nurses to check the MAR. The Administ physician 's orders comprehensive che error.  1b. Review of the ac 08/24/11 revealed a PO (by mouth) twice Medication Administ August 2011 reveal given twice a day at 0n 10/05/11 a revier monthly physician 'dated 08/24/11 that mouth (PO) every chours." The month the resident 's physical september and Oct that read: "(Senok every other week B MAR for September and the the medication was	the order for the MVI to be as but that the other nurses assumed that the order was the Administrator and the test is 15 AM, the DON stated was for the administrative physician's order sheet R and for the night shift old MAR against the new rator stated that checking the with the MAR was a ck and that this was a human dmission orders dated an order for Senokot S 1 tablet a day. Review of the tration Record (MAR) for ed that the medication was	į.	329	4. Results of the audits will be rethe Quality Assessment and Assis Committee monthly x 3 months. Quality Assessment and Assuran Committee will evaluate the effethe plan based on trends identified Quality Assessment and Assuran Committee will develop and impadditional interventions as needed continued compliance.	urance The ace octiveness of ed. The ace blement	11/04/2011
	67/02-00) Pravious Versions (	5 410 4005	311	F	ecility ID: 943003 If	continuation she	et Page 17 of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD B. WING		COMPLE	(X3) DATE SURVEY COMPLETED  10/07/2011		
		345262				71/4011		
	ROVIDER OR SUPPLIER ENTER HEALTH & REH	AB/HE		STREET ADDRESS, CITY, STATE, ZIP CO 1300 DON JUAN ROAD HERTFORD, NC 27944	JBE			
(X4) 1D PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 329	(DON) on 10/05/11 observed to review and stated that on to Senokot was to be stated that on the Senokot was to be stated that on the Senokot was written to be git two weeks. There we change the medicatother week.  The DON stated in 4:30 PM that she he physician and that Senokot to be given that the physician that the physician to orders but did not or the DON stated in 8:45 AM that the physician that the month the order the month the order the month the order the more than the ward clerk must the orders into the not find anywhere medications were the DON stated the ward clerk entering that now a Register The DON stated the way he ordered the way he ordered the way he ordered that she way he ordered that she way he ordered that she way he stated in the way he ordered that she way he stated in the way he ordered that she way he ordered that the way he ordered that she way he stated in the way he ordered that the way he way he way he way that the way he way	at 3:30 PM, the DON was the resident 's medical record he admission orders the given twice a day. The DON reptember monthly physician ' reptember MAR the medication ven twice a day once every vere no physician 's orders to tion from twice a day to every  an interview on 10/05/11 at ad spoken with the resident 's he changed the order for the in twice a day. The DON stated old her that he signed the recall what the orders were.  an interview on 10/06/11 at hysician 's orders and MAR for handwritten and at the end of ers were entered into the ard clerk. The DON stated that the had an error in putting computer because she could in the chart that the ordered as printed on the MAR. hat she had an issue with a g the medication orders and ored Nurse was in that position. hat the ordering physician was hey were still getting used to	F3	329	SARLS 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ULTIF	PLE CONSTRUCTION	TION (X3) DATE SURVEY COMPLETED		
		345262	8. WN	G		10/07/	2011
	OVIDER OR SUPPLIER	B/HE		1	REET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	on 10/06/11 at 9:03 / given once or twice a must have been a tyle in an interview with the DON on 10/07/11 at that the procedure wonerses to check the against the new MAR nurses to check the MAR. The Administration of the management of the manage	AM that Senokot should be a day and that the order entry po (typographical error).  The Administrator and the 8:15 AM, the DON stated as for the administrative physician's order sheet R and for the night shift old MAR against the new ator stated that checking the with the MAR was a sk and that this was a human admitted to the facility on agnoses including Multiple cidents (Strokes) and dical record revealed a one Order dated 09/18/11 for one drawn. The medical record revealed a one Order dated 09/21/11 was also so one Order dated 09/22/11 to one to see a depakote level in the depakote level in the results for a decrease of the depakote record.  The medical record.  The medical record is depakote level in the depakote level in the depakote results for a decrease of the depakote record.  The medical record.	F	329		ث المرشيد	
5000 000 00	ezzoa aon Previous Versions O	bsolete Event ID: 48R	S11	-	Facility ID: 943003	if continuation shee	t Page 19 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER:  A. BUILDING		DING	COMPL	COMPLETED		
		345262	B. WING	3		107/2011
	OVIDER OR SUPPLIER	\B/HE		STREET ADDRESS, CITY, STATE 1300 DON JUAN ROAD HERTFORD, NC 27944	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 329	2:35 PM that she wroto be drawn.  The SDC stated in a 3:45 PM that when the should have written filled out a lab sheet she ever signed off that the order was not the lab order sheet in SDC stated that the and the depakote level. In an interview with the Director of Nursing (AM the DON stated the order she should be	n interview on 10/06/11 at the nurse took the order she the order in the lab book and and put in the book before the order. The SDC stated of written in the lab book and and not been completed. The physician had been called wel would be drawn that day.  The Administrator and the DON) on 10/07/11 at 8:22 that when the nurse wrote I have filled out a lab sheet in the lab book and that the	F			
	6/30/11 with diagnostrauma, acute pain, The care plan dated #82 was at risk for a effects. A care plan assess behaviors m and notify the physic The care plan also i resisting care and re medications.  A record review of the a medication order of times daily as neede	s admitted to the facility on sees of motor vehicle accident substance abuse and anxiety. 6/30/11 indicated Resident anti-anxiety medication side approach to this risk was to anifested by the medication cian for medication reduction. Indicated behaviors of equesting the increase of the physician orders indicated for Vallum 2 milligrams 3 and dated 6/30/11.			in application to the second	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345262	B. WN	B. WING		10/07/2011	
	OVIDER OR SUPPLIER	B/HE	•	130	ET ADDRESS, CITY, STATE, ZIP CODE 10 DON JUAN ROAD RTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	The months of August were not found.  A record review of the Record (MAR) was condicated Valium was #82 in August 2011 of 11th, 13th -19th, 21st. The month of Octobe administered to Residuays: 1st - 3rd and the An interview with Nurindicated that Valium this morning. Reside anxiety by observing She indicated his behild.	nedication was conducted. t 2011 and October 2011  Medication Administration onducted. The MAR administered to Resident in the following days: 2nd - 26th and the 28th -31st. T 2011 indicated Vallum was dent #82 on the following ine 5th.  See #1 on 10/6/11 at 10:30am was given to Resident #82 in the following in the following ine 5th.  See #1 on 10/6/11 at 10:30am was given to Resident #82 in the following form the following following form the following	F .	329			
	revealed when psych administered, the nur drowsiness and any of These behaviors are facility behavioral for document "0" if there are behaviors, they hattempted and any chmood.  An Interview with the 10/7/11 at 8:33am incomonitoring sheets are	se staff look for signs of changes in behaviors. documented on a monthly in located in the MAR. They are no behaviors. If there ave to indicate interventions hanges in behaviors or Director of Nursing on dicated the facility behavioral a completed on residents edications. This sheet helps	And the property of the control of t		eque . Se t	age to S. F.	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345262	B. WIN	B. WNG		10/07/2011	
***	OVIDER OR SUPPLIER	в/не	STREET ADDRESS, CITY, STATE, ZIP CODE  1300 DON JUAN ROAD  HERTFORD, NC 27944			And the second	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	behavioral monitoring and completed.  483.60(c) DRUG REGIRREGULAR, ACT Of the drug regimen of reviewed at least one pharmacist.  The pharmacist must the attending physicianursing, and these resident are regident series are regident are sident series and administration record residents whose charmacist whose charmacist complete a resident series and administration record residents whose charmacist complete are sident series and administration record residents whose charmacist complete are sident series and administration record residents whose charmacist complete are sident series and administration record residents whose charmacist complete are sident series and administration record residents whose charmacist series and series	iform should be filled out GIMEN REVIEW, REPORT N each resident must be e a month by a licensed report any irregularities to an, and the director of ports must be acted upon.  is not met as evidenced liew and staff interviews the e that the consulting a comprehensive review of cions by failing to identify and between the physician 's the medication (MAR) for 1 of 10 sampled ts were reviewed (Resident		329	"Preparation and for executation of the correction does not constitute admiss agreement by the provider of the truth alleged or conclusions set forthin the deficiencies. The plan of correction is and/or executed solely because it is reprovisions of federal and state law."  1. Corrective action has been accorded to the alleged deficient pregards to resident #74. On 10/6/physician for resident #74 was a phone. Clarification of orders for Multivitamin and Senekot were Physician ordered a Basic Metal and Magnesium level at this time were obtained, physician notified copy of the results were put into record. No additional physician or received as a result of the lab wo #1 was educated regarding quest abnormal orders noted on medical administration record and compared orders to the original physician or in the medical record.  2. Facility residents have the pote effected by the alleged deficient phave had a 100% chart audit 10/2 by the consultant pharmacist to it report discrepancy between physicand the Medication Administration Adverse findings were brought to attention of the Director of Nursing ensure appropriate interventions with implemented as indicated.	ion or the facts statement of a prepared equired by the complished eractice in (2011 the notified by a received, colic Panel e. Results d, and a the medical orders were ork. Nurse ioning action uring those order located eractice	

Facility ID: 943003

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345262	B. WIN	B. WING		10/07/2011	
	OVIDER OR SUPPLIER	B/HE	STREET ADDRESS, CITY, STATE, ZIP CODE  1300 DON JUAN ROAD  HERTFORD, NC 27944				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 428	once a day as ordered On 10/05/11 a review monthly physician's dated 08/24/11 that in Vitamin-Minerals) 1 to (four times a day). "been signed by the re MAR for September 2 read: "(Multiple Vitamouth (PO) QID. The showed that the med times a day.  Record review showed pharmacist had review record on 09/26/11. Tindicate that there was physician's medications being additionally and stated that on the was ordered once a country the September month the September MAR as four times a day.  The DON stated in an 4:30 PM that she had physician and that he MVI to once a day and an magnesium level.	d that the MVI was given d. of the September 2011 orders revealed an entry ead: "(Multiple ablet by mouth (PO) QID The monthly orders had esident's physician. The 2011 showed an entry that min-Minerals) 1 Tablet by MAR for September loation had been given 4  and that the consulting wed the resident's medical there was no information to as a discrepancy with the on orders and the ministered to the resident.  With the Director of Nursing at 3:30 PM, the DON was be resident's medical record admission orders the MVI lay. The DON stated that on ally physician's orders and the medication was written  In interview on 10/05/11 at a spoken with the resident's changed the order for the dordered a chemistry panel rel. The DON stated that the the signed the orders but	I.		3. Systemic Measures put into pla ensure the alleged deficient practic recur include: New admission/rea records will be taken to the (IDT) Interdisciplinary Team Meeting, Methru Friday for review. The Direct Nursing/designee will validate Phyorders have been entered into the erecord system accurately. Re-Edithe pharmacy consultant complet 10/7/11 by Todd King, Pharm. Define Education reemphasized the improved the current month's Plant Order Statement (POS) to order medical record and Medication Administration Record. Eric Sconduct a comprehensive review Medication Administration Record. Entered in use. Audit will be conducted 2011. The DON/designee will random audits of physician order transcription, data entry, lab moninitiation of behavior monitorin indicated for a minimum 10 new physician orders weekly x 4 we monthly x 3 months. Negative to be addressed immediately. Rest audits will be reviewed weekly weeks and monthly times 3 months. Interdisciplinary Team Mee Additional interventions will be implemented as determined need IDT.	te does not dmission  Ionday or of vician lectronic ducation for eted on CGP. portance of hysicians is to the tratford ervice will wof the ord currently on 11-1-conduct er on itoring and g sheets as wor changed eks, then findings will alts of the times 4 in the during ting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS IDENTIFICATION NUMBER:  A. BUILDING		PLE CONSTRUCTION  G	ON (X3) DATE SUR COMPLETE	
		345262	B. WNG		10/07	//2011
	ROVIDER OR SUPPLIER	B/HE		REET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 428			F 428	F 428		
	The DON stated in an interview on 10/06/11 at 8:45 AM that she would have expected the consulting pharmacist to have identified the discrepancy during his monthly review.  The resident's Physician stated in a telephone interview on 10/06/11 at 9:03 AM that the MVI should only be given once a day and that the order entry must have been a typo (typographical error).		4. Results of the audits and the pharmacy recommendations wi and reviewed by the Quality As Assurance Committee monthly The Quality Assessment and As Committee will evaluate the eff the plan based on trends identifi Quality Assessment and Assura Committee will develop and im additional interventions as need	If be reported sessment and x 3 months. ssurance fectiveness of fed. The ince plement		
The consulting Pharmacist stated interview on 10/06/11 at 9:55 AM reviewed the previous months M but did not review the current MA was a specific issue that required The Pharmacist stated that if he order for the MVI to be given four would have questioned the order		at 9:55 AM that he usually months MAR on the chart current MAR unless there hat required him to do so. d that if he had seen the e given four times a day he		continued compliance.		11/04/2011
The control of the co	Director of Nursing on Administrator stated the monthly pharmacist re- irregularities and that	e Administrator and the 1 10/07/11 at 8:15 AM the hat the purpose of the eview was to look for the pharmacist should have the physician 's monthly				
	08/24/11 revealed an PO (by mouth) twice a Medication Administra	Review of the admission orders dated 4/11 revealed an order for Senokot S 1 tablet by mouth) twice a day. Review of the ication Administration Record (MAR) for last 2011 revealed that the Senokot was given a day as ordered.		was the the second of the second	and the second	The state of the s
	monthly physician 's	of the September 2011 orders revealed an entry ad: " (Senokot) 1 tablet by				, gran

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345262	B. WNG			10/07/2011		
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		JLD BE	(X5) COMPLETION DATE		
F 428	HRS (hours). "The maigned by the resident that read: "(Senokot) every other week BIDs showed that the Senometria and the 21st of the Record review showed pharmacist had review record on 09/26/11. The showed that there was physician should be senowed to review the and stated that on the Senokot was ordered. The DON stated in an 4:30 PM that she had physician and that he Senokot to be given to that the physician told.	er week BID/Q (every) 12 nonthly orders had been t's physician.  Der 2011 showed an entry 1 tablet by mouth (PO) /Q12 HRS. The MAR kot have been given on the month.  d that the consulting wed the resident's medical here was no information to a discrepancy with the on orders and the ministered to the resident.  th the Director of Nursing 3:30 PM, the DON was e resident's medical record admission orders the twice a day.  interview on 10/05/11 at spoken with the resident's changed the order for the wice a day. The DON stated	E.	428				
alegan (* )	The DON stated in an 8:45 AM that she would consulting pharmacist discrepancy during his	interview on 10/06/11 at d have expected the to have identified this monthly review.			Activities of the second se			
	interview on 10/06/11	ian stated in a telephone at 9:03 AM that Senokot or twice a day and that the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345262	B. WING			10/07/2011		
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHABIHE				STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO		OULD BE	(X5) COMPLETION DATE	
F 428	Continued From page 25 order entry must have been a typo (typographical error).  The consulting Pharmacist stated in a telephone interview on 10/06/11 at 9:55 AM that he usually reviewed the previous months MAR on the chart but did not review the current MAR unless there was a specific issue that required him to do so.  In an interview with the Administrator and the Director of Nursing on 10/07/11 at 8:15 AM the Administrator stated that the purpose of the monthly pharmacist review was to look for irregularities and that the pharmacist should have picked this up from the physician 's monthly orders.		F	428	DEFICIENCY)			
	, 🗻 M .							

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	D: 10/31/20 MAPPROVE	-1
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE S COMPL	SURVEY	<u>}</u> 1
		345262	B. WING		10#	10710044	
	PROVIDER OR SUPPLIER CENTER HEALTH & R	EHAB/HE	İ	REET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD	1072	27/2011	_
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	! (EACH CORRECTIVE ACTION SHOLL)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		4
	NFPA 101 LIFE SAFETY CODE STANDAR  Doors protecting corridor openings in other trequired enclosures of vertical openings, existing those constructed of 1% inch solid-bonded of wood, or capable of resisting fire for at least minutes. Doors in sprinklered buildings are required to resist the passage of smoke. The no impediment to the closing of the doors. It is are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulation all health care facilities.			"Preparation and /or executation of this plan of			
K 056 SS=E	Surveyor: 27871 Based on observation approximately 1:30 p were noncompliant, s going to clean linen s and latch for smoke t 42 CFR 483.70(a) NFPA 101 LIFE SAFI	ETY CODE STANDARD ic sprinkler system, it is the with NFPA 13, Standard		<ol> <li>Systemic measures implemented to ensure the same alleged deficient pradoes not recur include: the laundry dewill be checked Monday thru Friday Maintenance Director and documente This check will be on-going due to the variations in the humidity changing the door and the hazardous area being protected.</li> <li>Results of the Monday thru Friday will be reported to the Quality Assessing and Assurance Committee monthly x Quality Assessment and Assurance and Assurance and Assurance and Assurance Committee will evaluate the effectiveness of the plan based on tren identified and develop and implement additional interventions as needed to expect the same and the s</li></ol>	to actice cors by the ed. he fit of 3 y audit ment 3 The ed de ds		
BORATORY	DIRECTOR'S OR PROVINCE	USI ION IED DEDDESENTATIVES SIGN		continued compliance.	j	2/02/2011	,

TITLE

(X6) DATE

Deresa S. W. Icher RD, LNHA

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 tollowing 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 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

#### **发现在1990年发展的企业发展的企业发展的企业发展的企业企业** DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 01 - MAIN BUILDING 01 B. WING 345262 NAME OF PROVIDER OR SUPPLIER 10/27/2011 STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH & REHAB/HE 1300 DON JUAN ROAD HERTFORD, NC 27944 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 056 Continued From page 1 K 056. provide complete coverage for all portions of the building. The system is properly maintained in 1. Corrective action Will be accomplished accordance with NFPA 25, Standard for the on 11/17/2011 related to the alleged Inspection, Testing, and Maintenance of deficient practice in regards to the High/Low Water-Based Fire Protection Systems. It is fully switch in the riser room on the sprinkler supervised. There is a reliable, adequate water system. Hiller came is on 11/04/2011 supply for the system. Required sprinkler assessed and order the part. Installation of systems are equipped with water flow and tamper the High/Low switch will occur on switches, which are electrically connected to the 11/17/2011. building fire alarm system. 19.3.5 2. There is only one sprinkler system in the facility, therefore the only area affected. Correction will occur on 11/17/2011 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at 3. Systemic Measures put into place to approximately 1:30 pm onward, the following item ensure the same alleged deficient practice were noncompliant, specific findings include: does not recur include will include sprinkler system is not equipped with high/low monitoring the pressure gauge and following switch(riser room). any recommendations made by Hiller in regard to remaining in compliance, 42 CFR 483.70(a) 4. Maintenance Director will monitor pressure gauge and any recommendation made by Hiller and results will be reported to the Quality Assessment and Assurance Committee monthly x 3 The Quality Assessment and Assurance and Assurance

compliance.

12/02/2011

Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional

interventions as needed to ensure continued