**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
BRIAN CTR HLTH & REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE**
647 S RAILROAD ST BOX 966
WALLACE, NC 28466

**SUMMARY STATEMENT OF DEFICIENCIES**
Each deficiency must be preceded by full regulatory or RSC identifying information.

**F 164**
483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

Angela Leonard, RN, and Director of Nursing immediately provided RN #1 re-education on 12-13-12 regarding HIPPA guidelines to include privacy practice.

The facility Director of Nursing completed facility audit observations to ensure that each facility licensed nurse was compliant with HIPPA guidelines to include privacy of medication and treatment record.

The facility licensed nursing staff received re-education regarding HIPPA guidelines to include privacy practice regarding covering of medication and treatment records on 12-13-12 by Staff Development Coordinator. The facility newly hired licensed nurses will receive education during the new hire orientation regarding HIPPA guidelines.

**This REQUIREMENT is not met as evidenced by:**
Based on observation and staff interview, the facility failed to ensure that the MAR (medication administration record) was kept covered to maintain resident privacy for 2 of 10 residents (#7 and #49). The findings include:

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**
Administrator

**DATE**
1/8/12

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 discloseable 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 discloseable 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.
The facility staff to include contracted employees were provided re-education on the privacy rules and HIPPA guidelines on 12-13-12 by Staff Development Coordinator and Health Information Clerk and completed on 1-10-13. The facility newly hired staff will receive education during the new hire orientation regarding HIPPA guidelines by facility Staff Development Coordinator.

The facility Director of Nursing will complete 1 – 2 random sample observation of licensed nurses to ensure that HIPPA guidelines are in place related to covering of medication records and/or treatment Monday – Friday times four weeks alternating shifts.

The facility Director of Nursing will report results of observation to QAPI committee monthly x 2. The QAPI committee will review and analyze for trends.
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<td>During an interview with the Director of Nursing (DON) on 12/13/12 at 11:15 AM it was revealed. &quot;</td>
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|  |  |  | I expect that the MAR always be covered if the nurse is not at the cart. We do go over HIPPA training during orientation."
| F253 |  |  | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES |
|  |  |  | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. |
|  |  |  | This REQUIREMENT Is not met as evidenced by: |
|  |  |  | Based on observation and resident and staff interviews, the facility failed to ensure that the pull cords for the overbed lights were long enough for the resident to reach for 2 of 18 rooms (room 208) and failed to ensure that the overbed light was functioning for 1 of the residents in room 208 (resident #7). The findings include: |
|  |  |  | An observation on 12/10/12 at 6:00PM revealed that the pull cords for the overbed lights for both bed 1 and bed 2 in room 208 were not reachable by the residents in the beds. The cord for bed #1 was about 4 inches long and the cord for bed #2 was about 2 inches long. |
|  |  |  | An observation on 12/11/12 at 3:55 PM revealed that the pull cords for both bed 1 and bed 2 in room 208 were not reachable by the residents in the beds. The cord for bed #1 was about 4 inches long and the cord for bed #2 was about 2 inches long. During this observation the resident |

The facility Maintenance Director replaced the light cord in 208 beds 1 and 2. The Maintenance Director ensured that 208 bed 1 and 2 could reach by having the residents complete a return demonstration. The Facility Maintenance Director Repaired Resident #7 light by adjusting the bulb.

The facility Maintenance Director completed facility review of each resident room to ensure that each resident light was in working condition and that each resident over bed light had a reachable pull cord on 12-14-12. The Maintenance Director will complete room observations at least once a month to ensure that resident lights are properly functioning and each over bed light has reachable light cord.
Facility resident ambassador will complete 1-2 sampled room observation weekly times four. The facility will communicate any concerns related to lights/ or light cords to the facility Maintenance Director by using the maintenance clipboard.

The facility staff were provided re-education regarding process when a maintenance issue identified to include lights and/or light cords given by the Staff Development Coordinator and Health Information Coordinator started 12/13/12 and completed on 1/10/13.

The facility Maintenance Director will report results of room observation to Quality Assurance committee (QAPI) monthly x 2. The QAPI committee will review and analyze for trends. 1-10-13
F 253: Continued From page 4

The Facility Director of Nursing completed observation audit of facility areas where medication was stored to ensure that no medication were stored with expiration dates on 12-13-12 or before.

The facility Director of Nursing and/or Assistant Director of Nursing will complete weekly audits of medication room times four weeks to ensure medications are not stored out of date.

Facility licensed nurses were provided re-education regarding the process of checking medication prior to administration for expiration dates on 1-04-13 by facility Staff Development Coordinator and completed on 1-10-13. The facility newly hired licensed nurses will review education regarding medication stored to include checking for expiration dates during new hire orientation.
F 431
Continued From page 5

This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interviews, the facility failed to ensure that there were no expired items in one of one medication storage rooms.
Findings include:

On 12/13/2012 at 4:00 PM, in the only medication storage room in the facility, there were six boxes of glucose control solution (used to test the accuracy of a glucometer, which is used to test blood sugar), dated 2012-10 (October, 2012). Each box contains two 4 ml bottles, one marked hi and one marked lo. Each bottle has an expiration date of 2012-10 (October, 2012). There were three bottles of Benadryl oral solution (an antihistamine for allergy relief or common cold), two with an expiration date of 09/12 (September, 2012), and one with an expiration date of 07/12 (July, 2012).

On 12/13/2012 at 4:40 PM, in an interview, the Assistant Director of Nursing (ADON) stated that the transportation aide also stocks the med storage room. The ADON also stated that this same aide is responsible for inventory.

On 12/13/2012 at 4:55 PM, the Director of DON Nursing (DON) stated, in an interview, that the Pharmacy comes every four to six weeks, but mainly checks the carts, although the Pharmacy sometimes rotates the stock. The DON also stated that all meds are checked for expiration when they are brought out of the medication storage room.

The facility Director of Nursing will report results of observation to QAPI committee monthly for two months.
The QAPI committee will review and analyze for trends.
In an interview on 12/13/2012 at 1:45 PM, the aide who is in charge of the medication storage room supply and inventory, stated that she does an inventory every week which consists of rotating the stock and checking expiration dates. The aide stated that if stock is expired, she puts it in the bin to go back to the pharmacy.
K 000  INITIAL COMMENTS

This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special Locking arrangements, and is equipped with an automatic sprinkler system.

CFR#: 42 CFR 483.70 (a)
NFPA 101 LIFE SAFETY CODE STANDARD

K 062  SS=D

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.8.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:
Based on the observations and staff interviews on 1/24/2013 the following Life Safety Item was observed as noncompliant, specific findings include: The post indicator valve (PIV) just outside the sprinkler riser room failed to give a supervisory signal at the fire alarm control panel when tested.

NOTE: This deficiency was corrected by the facilities contractor before the end of the life safety survey.

CFR#: 42 CFR 483.70 (a)

K 000

The alleged deficiency noted as "post indicator valve failed to give a supervisory signal at the fire alarm control panel" was corrected before end of survey.

The Maintenance Director will do a weekly test of the supervisory system with a minimal turn of the valve sufficient to initiate trouble signal for the next four weeks, and then monthly thereafter during regular fire drills for the next three months. Any negative results will be reported immediately to the Administrator and any repairs done immediately.

All results will be reported to and discussed during the next three monthly Safety Committee meetings and continue with quarterly reports thereafter until next annual survey. Correction date of 1/24.

1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

[Title]

[Signature]

[Date] 2/5/13