

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2014
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		
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F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interviews, record reviews, family interview and staff interviews, the facility failed to give 2 of 3 sampled residents a choice regarding the number of showers they preferred a week and failed to provide the showers per the schedule (Residents #82 and #123).</p> <p>Findings included:</p> <p>1. Resident #82 was admitted to the facility on 01/01/14, Her diagnoses included subdural hemorrhage, muscle weakness, chronic kidney disease, post cerebral vascular accident and a new clavicle fracture.</p> <p>The admission Minimum Data Set (MDS) dated 01/08/14 coded her with being cognitively intact, requiring extensive assistance with most activities of daily living (ADL) and being nonambulatory. She had no behaviors.</p> <p>The Care Area Assessment (CAA) for activities of daily living dated 01/04/14 stated Resident #82 had right side weakness, a fractured clavicle (Left) and required assistance of staff for most</p>	F 242	<p>F242</p> <hr/> <p>1. Corrective action was accomplished for the alleged deficient practice by the DON conducting interviews on 03-07-14, with resident #82 and #123 regarding their preferences for shower schedules. Each resident's shower schedule was adjusted to reflect preferences accordingly.</p> <p>2. All residents who are able to be showered have the potential to be affected by this alleged deficient practice. The DON or Designee will conduct an interview with these residents to verify their preferences regarding shower schedules. Each resident's shower schedule will be adjusted to reflect these preferences. These interviews will be completed by 04-04-14.</p> <p>3. Licensed Nursing Staff will be educated by the DON or Designee on completion of the interview regarding showering preferences upon admission.</p>	3/31/14	

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

TITLE

(X6) DATE

Electronically Signed

03/27/2014

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 242	<p>Continued From page 1 ADLs.</p> <p>On 03/04/14 at 8:21 AM, Resident #82 was dressed, well groomed, sitting in her wheelchair eating breakfast in her room. At 10:08 AM, the resident was observed walking in the hall with therapy and her family was present.</p> <p>On 03/04/14 at 11:20 AM, Resident #82 stated she was supposed to have two showers per week, one this date (Tuesday) and one Saturday. She stated she does not always get a shower. She acknowledged that sometimes she felt sick in the mornings but that a shower always made her feel better. She stated she had never refused a shower when offered. She stated this morning she was supposed to get a shower but did not get one. She stated she had a family meeting this morning but was waiting for her shower. She stated she was never given a choice for number of showers and would take one daily if allowed, but would take one every day she was supposed to have one (twice a week). When she has asked about showers, staff have told her she hasn't felt good. Resident #82 again stated she had never refused a shower even when feeling poorly.</p> <p>Review of the nurse aide assignment sheets dated 03/05/14, which indicate individualized care for residents, noted Resident #82's shower days were Tuesdays and Saturdays.</p> <p>Review of the care tracker report, completed on the computer by nurse aides documenting showers/baths revealed that since Resident #82 was admitted on 01/01/14, she had received a "shower" only once on 03/01/14.</p>	F 242	<p>Nursing Staff will be re-educated by the DON or Designee on adhering to resident preferences regarding showering schedules, communicating a resident's request for change in showering schedules to the DON, ADON, or Unit Manager, and accurate documentation of completion of showers. The education will be completed by 04-04-14. The DON or Designee will randomly interview 5 residents 3 times per week for 4 weeks then weekly for 8 weeks to verify showering preferences are being followed and documentation reflects showers are provided according to the resident's preferences. Opportunities will be corrected as identified.</p> <p>4. Measures to ensure that corrections are achieved & sustained include: The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 242	<p>Continued From page 2</p> <p>On 03/05/14 at 9:54 AM, she was in bed. She stated she did not get a shower yesterday and the last time she was showered was Saturday. She stated she was waiting to be cleaned up in order to go to dialysis. At 10:30 AM, Resident #82 was out of bed, in her wheelchair, preparing to go to dialysis. At 11:14 AM, she was still waiting to go to dialysis and stated she was not given a shower, only washed up.</p> <p>On 03/06/14 at 12:00 noon, Nurse #4 stated she thought Resident #82 received a shower on Tuesday (03/04/13) and she would double check the refusal papers staff fill out for refusals. She never provided any more documentation.</p> <p>On 03/06/14 at 12:22, Nurse Aide (NA) #5 stated she offered the resident a shower on Tuesday but she said she had no time for a shower due to a family meeting with therapy. NA #5 stated she went back later to offer a shower and she refused. NA #5 stated she offered to change her showers to second shift but Resident #82 stated she wanted a shower on first shift. This nurse aide stated she reported refusals to the nurse on duty and it was documented. At 12:26 PM, NA #5 came to the surveyor to report that she gave good bed baths daily to everyone.</p> <p>Resident #82 stated on 03/06/14 at 2:00 PM that she never recalls refusing a shower. The resident reported that on Tuesday the NA came to her and asked if the resident was aware of the family meeting. The resident stated she was aware and the NA told her she had no time to give a shower then. Resident #82 stated she always took a shower daily at home even when not feeling well as they made her feel better. Resident #82 further stated that if she was nauseated or sick, staff</p>	F 242			

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F 242	<p>Continued From page 3</p> <p>decide she was too sick to shower and they decide on their own to give her a bed bath.</p> <p>Review of the medical record revealed no documented refusals for showers. Review of the hygiene sheets used to record showers and refusals revealed the only sheet found by the facility was dated 03/01/14 which indicated a shower/bed bath was provided.</p> <p>Interview with the Director of Nursing (DON) on 03/06/14 at 2:04 PM revealed on admission a form is completed to obtain preferences and information to get to know the resident individually. The form indicated the of day a shower was preferred. DON stated showers are scheduled twice a week. No one asked a resident their preference for number of showers per week, only the time of day.</p> <p>Interview with the DON and Assistant Director of Nursing (ADON) on 03/06/14 at 2:40 PM revealed Resident #82 had been refusing care. The ADON stated the facility offered to change days of her planned showers to accommodate her preference of staff and dialysis days. The ADON stated that a shower refusal would be considered rejection of care but staff always gave bed baths.</p> <p>On 03/07/14 at 10:00 AM an interview was conducted with Resident #82 and her responsible party. Family stated that the resident had only gotten 2 showers since admission. Family stated that staff told them the resident refused showers but they stated staff always promised to come back to do the shower but they did not return. Family stated they complained about the lack of showers at a care plan meeting a couple of weeks ago at which time the facility changed the</p>	F 242			

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F 242	<p>Continued From page 4</p> <p>schedule for Tuesdays and Saturdays. Family stated they told the facility they wanted the resident showered daily to which they did not respond. Family stated they attributed the lack of showers to lack of communication in the facility.</p> <p>Interview with the Consultant Nurse and DON on 03/07/14 at 4:25 PM revealed starting this date, the facility would ask about the number of showers residents requested per week. They stated they started looking yesterday at the shower documentation and were not sure if the documentation was accurate or if showers were not really being given.</p> <p>2. Resident #123 was admitted to the facility on 12/23/13 and readmitted on 02/07/14 after a hospitalization. His diagnoses included metabolic encephalopathy, acute chronic renal failure, bilateral lower amputation and Parkinson's disease.</p> <p>The admission Minimum Data Set (MDS) dated 12/30/13 coded him cognitively intact, having no behaviors, and requiring extensive assistance with hygiene.</p> <p>During interview on 03/03/14 at 2:16 PM, Resident #123 stated he was not able to choose how many times per week he took a shower. He stated they were given on Tuesdays and Fridays. If he were at home, he stated would take about 6 showers per week. He further stated he was never asked how many showers he wanted to take in the facility.</p> <p>On 03/06/14 at 8:24 AM Nurse Aide (NA) #4 stated Resident #123 never expressed a desire to have more showers.</p>	F 242			

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F 242	<p>Continued From page 5</p> <p>On 03/06/14 at 10:06 AM Resident #123 stated he specifically asked NA #4 about more showers and she told him he could only have 2 per week.</p> <p>On 03/06/14 at 10:51 AM, NA #4 stated if someone asked for an additional shower, she would give them one. If the resident wanted a routinely added shower, she would relay that information to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) who made the shower schedule.</p> <p>On 03/06/14 at 2:15 PM, DON stated that on admission, residents are not asked how many showers they want each week or the day of the week. They are asked what time of day they prefer. The facility would try to accommodate a special request related to showers. At 2:18 PM the DON and ADON reported they asked Resident #123 how many showers he would want per week and he said 3. They stated they would change the schedule. At this time the care tracker documentation which logged the showers/baths provided by the nurse aides was reviewed with the DON and ADON. Per this documentation, Resident #123 had only received 2 showers between 02/08/14 and 03/05/14. The documentation reflected he received a shower on 02/15/14 and 02/26/14. The other days he received a bed bath. The DON stated she could not argue with the documentation.</p> <p>On 03/06/14 at 3:47 PM, Resident 3123 stated that 3 showers per week would be enough. He further stated no one asked him when he first got here how many showers he would like. He said he had only been getting one shower per week but that staff washed him up every day.</p>	F 242			

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F 242	Continued From page 6	F 242			
F 272 SS=B	<p>Interview with the Consultant Nurse and DON on 03/07/14 at 4:25 PM revealed starting this date, the facility would ask about the number of showers residents requested per week. They stated they started looking yesterday at the shower documentation and were not sure if the documentation was accurate or if showers were not really being given.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;</p>	F 272		3/31/14	

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F 272	<p>Continued From page 7</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide complete Care Area Assessments which included underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions for comprehensive Minimum Data Set assessments for 6 of 12 residents. (Residents #121, #112, #129, #160, #123, and #130).</p> <p>Findings included:</p> <p>1. Resident #121 was admitted to the facility 01/14/14 with diagnoses which included sepsis, pneumonia, and diabetes mellitus. The admission Minimum Data Set (MDS) dated 01/21/14 indicated the resident experienced moderately impaired cognition. The MDS specified Resident #121 required extensive staff assistance with all activities of daily living except eating which required staff supervision. The resident was also on a mechanically altered diet.</p> <p>A review of Resident #121's weights revealed from 1/14/14 to 2/17/14 there was a 6.5% weight</p>	F 272	<p>F272:</p> <p>Criteria #1: The RCMD or MDS Coordinator will modify and correct the CAAs associated with most recent MDS assessments for Residents # 121, #112, #129, #160, #123, and #130 by 04-04-14.</p> <p>Criteria #2: All residents who have received a Comprehensive MDS assessment have the potential to be affected by this alleged deficient practice. . The RCMD or designee will complete an audit of all residents receiving a Comprehensive MDS assessment during the last 30 days to verify accurate CAA completion per the RAI manual guidelines. Corrections will be made manually to each CAA as opportunities are identified. This audit will be completed by 4-4-14.</p> <p>Criteria #3: The RCMC will re-educate the IDT members on accurate CAA</p>		

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F 272	<p>Continued From page 8 loss.</p> <p>A Care Area Assessment (CAA) dated 01/28/14 and related to nutrition was reviewed. The analysis of findings contained the following information: "will proceed to care plan due to bmi and pressure ulcers." The CAA did not contain a summary addressing Resident #121's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions.</p> <p>An interview was conducted with the Dietary Manager (DM) on 03/06/14 at 10:05 AM. The DM stated she wrote the CAA for nutrition. She explained she was unaware of what information should be in the CAA and the format that was required. The DA acknowledged there was no summary that explained Resident #121's risk for weight loss, underlying causes or risk factors that must be considered in developing individualized care plan interventions.</p> <p>During an interview on 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDS process. The Consultant Nurse, also present at this time, confirmed that the CAA needed more detailed information for a summary.</p> <p>2. Resident #112 was admitted to the facility 01/25/14 with diagnoses which included end stage renal disease and diabetes mellitus. An admission Minimum Data Set (MDS) dated 02/01/14 coded the resident's cognition was intact. The MDS specified Resident #112 required extensive staff assistance with most</p>	F 272	<p>completion per RAI manual guidelines. The RCMD will randomly monitor 5 Comprehensive MDS assessments per week for 12 weeks to verify accurate CAA completion per the RAI manual guidelines. Opportunities will be corrected as identified.</p> <p>Criteria #4 The results of these audits and interventions will be submitted to the QAPI Committee by the RCMD or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 272	<p>Continued From page 9</p> <p>activities of daily living but was independent with eating.</p> <p>A Care Area Assessment (CAA) dated 02/05/14 and related to nutrition was reviewed. The analysis of findings contained the follow information: "will proceed to care plan due to hemodialysis, poor po (by mouth) intake, therapeutic restrictions and pressure ulcers." The CAA did not contain a summary addressing Resident #112's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions.</p> <p>An interview was conducted with the Dietary Manager (DM) on 03/07/14 at 10:17 AM. The DM stated she wrote the CAA related to nutrition. She stated Resident #112's CAA related to nutrition did not reflect the resident's needs. She explained fluid restrictions, special dietary needs, or what nutritional care the facility was providing for the resident was not contained in the CAA.</p> <p>During an interview on 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDS process. The Consultant Nurse, also present at this time, confirmed that the CAA needed more detailed information for a summary.</p> <p>3. Resident #129 was readmitted to the facility 01/15/14 with diagnoses which included dementia and aftercare for a hip fracture surgical repair. An admission Minimum Data Set (MDS) noted the resident with severely impaired cognition. The MDS specified Resident #129 required extensive staff assistance with all activities of</p>	F 272			

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F 272	<p>Continued From page 10</p> <p>daily living and was admitted with a stage 3 pressure ulcer.</p> <p>A Care Area Assessment (CAA) dated 01/29/14 and related to pressure ulcers was reviewed. The analysis of findings contained the following information: "Resident triggered d/t (due to) being admitted with pressure ulcers, stage III on sacrum, stage1 bilateral heels." The CAA did not contain a summary addressing Resident #129's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions.</p> <p>Interview with the MDS coordinator on 03/07/14 at 3:16 PM revealed that she normally explained why a resident needed assistance via the diagnoses and risk for decline. She stated she thought checking the computerized options was enough explanation in a CAA. She stated she did not know she should be summarizing the findings.</p> <p>During an interview on 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDS process. The Consultant Nurse, also present at this time, confirmed that the CAA needed more detailed information for a summary.</p> <p>4. Resident #160 was admitted to the facility 11/18/13 with diagnoses which included sacral decubitus ulcers, severe malnutrition, and a self-care deficit. An admission Minimum Data Set (MDS) dated 11/15/13 noted the resident's cognition was intact. The MDS specified the resident required extensive staff assistance with activities of daily living except for eating. The</p>	F 272			

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F 272	<p>Continued From page 11</p> <p>MDS noted the resident was admitted with 3 stage 3 pressure ulcers and 1 unstageable pressure ulcer.</p> <p>A Care Area Assessment (CAA) dated 11/20/13 and related to pressure ulcers was reviewed. The analysis of findings contained the following information: "Resident triggered d/t (due to) having pressure ulcers on admission, wound treated daily. resident has been loosing weight." The CAA did not contain a summary addressing Resident #160's underlying causes, risk factors, and factors that must be considered in developing individualized care plan interventions.</p> <p>Interview with the MDS coordinator on 03/07/14 at 3:16 PM revealed that she normally explained why a resident needed assistance via the diagnoses and risk for decline. She stated she thought checking the computerized options was enough explanation in a CAA. She stated she did not know she should be summarizing the findings.</p> <p>During an interview on 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDS process. The Consultant Nurse, also present at this time, confirmed that the CAA needed more detailed information for a summary.</p>	F 272			

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F 272	Continued From page 12 5. Resident #123 was admitted to the facility on 12/23/13 and readmitted on 02/07/14 after a hospitalization. His diagnoses included metabolic encephalopathy, acute chronic renal failure, bilateral lower amputation and Parkinson's disease. The admission Minimum Data Set (MDS) dated 12/30/13 coded him cognitively intact, having no behaviors, requiring extensive assistance with hygiene, and having no falls since admission. a. The CAA relating to falls dated 01/06/14 noted the analysis of findings summarized as "Resident triggered d/t needing extensive assistance with toileting, and resident (sic) being on lasix. Dx. edema, above knee amputation. At risk for falls." The reason noted a care plan would be developed was call bell and all personal belongings at reach, bed in low position, resident has a torso support while in w/c for positioning. b. The Care Area Assessment (CAA) relating to activities of daily living (ADL) dated 01/07/14 noted the analysis of findings summarized as "Resident triggered d/t (due to) needing extensive assist with most ADL's. Dx. (Diagnoses) left above knee amputation. At risk for decline." The reason noted a care plan would be developed was that staff were to assist with ADLs as needed, keep call bell in reach and all therapies to work with him to improve his maximum independence. The system checked problems included a recent hospitalization and pain with the	F 272			

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F 272	<p>Continued From page 13</p> <p>risk of social isolation and complication of immobility.</p> <p>Neither CAA identified Resident #123's functional capacity including strengths, weaknesses, a full documentation or description of the problem and health status, and his need for assistive devices. This included how the Parkinson's disease and subsequent tremors affected his abilities to be mobile resulting in the need for a torso support and the fact he was a bilateral amputee.</p> <p>Resident #123 was observed on 03/03/14 at 11:45 AM sitting upright in a high back wheelchair, with anti tip bars on the back of the wheelchair, and both legs amputated. On 03/05/14 at 11:49 AM he was observed in bed, with a bolster on the open side of his bed, he had activated the call light and requested staff get him up. At 12:01 PM, Resident #123 was transferred via a total lift. On 03/06/14 at 10:06 AM he was observed self propelling his wheelchair on another hall.</p> <p>On 03/06/14 at 3:42 PM Nurse #5 stated Resident #123 used to be much more spastic in his upper body movements and he was much more confused. She related he needed the torso support because his spastic movements caused him to almost throw himself out of the chair and he could not balance upright in the chair.</p> <p>On 03/06/14 at 4:15 PM the Physical Therapist also stated he has ataxia type movements and pelvic thrusting causing him to be a fall risk.</p> <p>Interview with the MDS Coordinator on 03/07/14 at 3:16 PM revealed that she normally explained why a resident needed assistance via the</p>	F 272			

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F 272	<p>Continued From page 14</p> <p>diagnoses and risk for decline. She stated she thought checking the computerized options were enough explanation in a CAA. She stated she did not know she should be summarizing the findings. She stated the need for a torso support was related to his amputation, not his spastic movements.</p> <p>On 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDSs. The Consultant Nurse, also present at this time, confirmed that the summary needed more detailed information for a summary.</p> <p>6. Resident #130 was admitted on 03/26/12. His diagnoses included dementia, diabetes, hypertension, and thyroid disorder. The most recent Minimum Data Set, an annual dated 01/20/14, coded Resident #130 with severely impaired cognitive skills, having no behaviors, and requiring extensive assistance with hygiene. He was coded as having no range of motion impairment, and no falls since previous assessment.</p> <p>The Care Area Assessment (CAA) dated 01/30/14 for falls noted the analysis of findings summarized as "resident has weakness and unsteady gait needs ex (extensive) assist with transfer and mobility." The reason the care plan was to be developed was "staff will provide assist with mobility and transfers as needed."</p> <p>The CAA did not identified Resident #130's functional capacity including strengths, weaknesses, a full documentation or description of the problem and health status. Review of history noted in the care plan, he had a history of</p>	F 272			

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F 272	Continued From page 15 falling, required chair and bed alarms, gripper socks, and a floor mat on open side of bed. The CAA did not describe his severe cognitive impairment. Interview with the MDS coordinator on 03/07/14 at 3:16 PM revealed that she normally explained why a resident needed assistance via the diagnoses and risk for decline. She stated she thought checking the computerized options was enough explanation in a CAA. She stated she did not know she should be summarizing the findings. On 03/07/14 at 4:25 PM, the Director of Nursing stated MDS staff was under the leadership of the Administrator and she was unfamiliar with the MDSs. The Consultant Nurse, also present at this time, confirmed that the summary needed more detailed information for a summary.	F 272			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to administer the correct amount of a nutritional supplement for 1 of 1 resident observed receiving a nutritional supplement. (Resident #37) Findings included: A review of Resident #37's medical record	F 281	F281 _____ 1. A Medication Variance was completed regarding the inaccurate dose of nutritional supplement administered to Resident # on 03-05-14 by the DON. The Physician's order was clarified on 03-05-	3/31/14	

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F 281	<p>Continued From page 16</p> <p>revealed the resident was admitted to the facility 12/18/06. Current diagnoses included dysphagia and advanced dementia.</p> <p>A review of a dietary note written by the dietary manager on 10/28/13 revealed Resident #37 had experienced weight loss. The note specified Resident #37 received 4 ounces of a nutritional supplement and remained at risk for further weight loss.</p> <p>An annual Minimum Data Set (MDS) dated 01/15/14 indicated the resident experienced memory loss and severely impaired cognition. The MDS specified the resident required extensive to total assistance of staff for all activities of daily living including eating.</p> <p>A care plan dated 01/13/14 identified Resident #37 with the potential for weight loss related to mental status, medications, and dysphagia. The care plan goal was for Resident #37's weight to be stabilized within 120 pounds to 130 pounds through the next 90 days. Interventions included provide nutritional supplements as ordered.</p> <p>A review of Resident #37's monthly orders for March 1, 2014 through March 31, 2014 revealed a physician's order for house supplement 1 serving 3 times a day at 10:00 AM, 4:00 PM, and 8:00 PM.</p> <p>During a medication administration observation on 03/03/14 at 4:22 PM, Certified Medication Aide (CMA) #1 was observed pouring a nutritional supplement into a plastic cup without measuring the amount of supplement. The cup was observed filled to the top of the fourth ring from the bottom of the cup. CMA #1 administered the</p>	F 281	<p>14 by the DON to reflect the specific dose for administration.</p> <p>2. Residents receiving liquid nutritional supplement have the potential to be affected by this alleged deficient practice. Physician's orders for these residents were clarified to reflect the specific dose for administration by 04-04-14.</p> <p>3. Measures put into place or system changes initiated to ensure the alleged deficient practice does not recur include: Licensed Nurses and Certified Medication Aides were re-educated on techniques for accurate administration of liquid nutritional supplements, this education will be completed by 04-04-14. The DON, ADON, Unit Manager or designee will randomly observe 5 medication passes 3 times per week for 4 weeks then weekly for 8 weeks to verify accurate administration of liquid nutritional supplements.</p> <p>4. The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 281	<p>Continued From page 17</p> <p>nutritional supplement to Resident #37 with a medication that was also due at that time.</p> <p>An interview with Nurse #1 was conducted on 03/04/14 at 5:02 PM. Nurse #1 stated a "serving" of house supplement, used as a nutritional supplement, was 4 ounces.</p> <p>An interview was conducted with CMA #1 on 03/04/14 at 5:19 PM. CMA #1 stated she had been administering medications for about 4 years and usually worked Resident #37's hall on the 3:00 PM to 11:00 PM shift. CMA #1 stated she had worked at this facility so long, she knew a "serving" of house supplement was 4 ounces. She stated she always filled the plastic cup to the fourth ring from the bottom of the cup. CMA #1 was unaware an ounce contained 30 centimeters (cc). CMA #1 utilized a medication dose cup to measure out an ounce of water by filling the dose cup to the marking that indicated 30 cc. She poured the measured water into a plastic cup as used with Resident #37's nutritional supplement. After CMA #1 measured out 4 dose cups of water filled to the 30 cc marking, the fluid came to approximately 45 cc above the fourth ring mark in the plastic cup. CMA #1 acknowledged she had not been administering 4 ounces of the nutritional supplement as ordered by the physician.</p> <p>An interview with the Director of Nursing (DON) was conducted on 03/04/14 at 5:33 PM. The DON stated at this facility, a "serving" of a nutritional supplement was considered 4 ounces. She added all the medication administration staff had been informed of this in orientation and with annual pharmacy training. She stated she expected nutritional supplements were measured accurately.</p>	F 281			

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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nail care to 1 of 3 sampled residents reviewed for provision of care with activities of daily living (ADL). (Resident #130).</p> <p>Findings included:</p> <p>Resident #130 was admitted on 03/26/12. His diagnoses included dementia. The most recent Minimum data set, an annual dated 01/20/14 coded Resident #130 with severely impaired cognitive skills, having no behaviors, and requiring extensive assistance with hygiene.</p> <p>The Care Area Assessment (CAA) dated 01/30/14 for cognition stated Resident #130 was alert with confusion, having severely impaired decision making and being able to express needs to staff. There was no CAA related to behavior or activities of daily living as these areas did not trigger an assessment.</p> <p>Review of the nursing notes revealed no indications of any refusals of care or any types of behaviors. It was noted in a care plan that he refused gerisleeves on 03/02/14.</p>	F 312	<p>F312 _____</p> <p>1. Corrective action was accomplished for the alleged deficient practice by the RCS providing nail care to resident #130 on 03-07-14.</p> <p>2. All dependant residents have the potential to be affected by the same alleged deficient practice. An audit of all dependent resident residents will be completed by the DON or designee by 4-4-13, to validate nailcare was provided, any opportunities will be corrected as identified.</p> <p>3. Nursing Staff will be re-educated by the DON or designee on providing assistance with Activities of Daily Living to include nailcare by 04-04-14. The Director of Nursing or designee will randomly observe 10 residents 3 times per week for 4 weeks then weekly for 12 weeks to verify residents are receiving required assistance with Activities of Daily Living including nailcare Opportunities will be corrected as identified.</p>	3/31/14	

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F 312	<p>Continued From page 19</p> <p>On 03/04/14 at 8:40 AM, Resident #130 was observed in bed with long jagged nails, some with brown substance under the nail. Observation on 03/04/14 at 1:45 PM revealed he was up and dressed in his wheelchair. His nails remained long, jagged and some had a brown substance under the nail. The resident stated at this time the nurse cleaned his nails yesterday.</p> <p>The nurse aide care guide, which nurse aides carry with them to direct individual resident care needs, dated 3/5/14 noted Resident #130 had his shower on Wednesdays and Sundays on first shift. This sheet contained no indications that Resident #130 had behaviors of refusing care.</p> <p>Resident #130 was observed on 03/05/14 at 8:55 AM up in his wheelchair in his room eating breakfast. His nails were long and jagged but clean. Resident #130's nails remained long and jagged when observed on 03/05/14 at 11:17 AM, at 2:53 PM, and on 03/06/14 at 8:56 AM.</p> <p>On 03/06/14 at 8:56 AM, Nurse Aide (NA) #2 stated Resident #130 did not want his nails cut during his shower yesterday. She stated he did not want a shower either. She stated she would go back and offer care again when a resident refuses but that a resident had the right to say no to care. She further stated he often refused care, including showers. She stated she gave him a bed bath daily and reported to the nurse any refusals for care.</p> <p>Resident #130's nails were observed long and jagged on 03/06/14 at 10:08 AM.</p> <p>Interview with Nurse #2 on 03/06/14 at 10:53 AM revealed that Resident #130 was very mellow. He</p>	F 312	<p>4. The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 312	<p>Continued From page 20</p> <p>further stated staff reported to him when residents refused care and he would go talk to the resident about care. He stated he tried to talk Resident #130 into having his nails cut yesterday but he refused. Nurse #2 stated he should document refusals of care in the clinical record. Nurse #2 also stated Resident #130 had no form for monitoring resistance or refusals for care.</p> <p>Interview with the Director of Nursing (DON) on 03/06/14 at 2:50 PM revealed Resident #130 will agree to care one day and then refuse care the next day describing him as "on again, off again." She stated hygiene forms were used on each shower day and before a refusal was accepted, 2 staff had to make 3 attempts to try and provide care. Review of the hygiene forms revealed:</p> <p>a. on 02/01/14 he refused a shower and agreed to a bed bath. Nothing was initialed indicating he received nail care.</p> <p>b. on 02/26/14 an initial indicated he received a shower and nail care.</p> <p>c. on 03/05/14 revealed NA #2 initialed indicating Resident #130 was shaved, toenails were clean and clipped, his fingernails were cleaned, the word clipped was crossed out, and he had a bed bath or shower. There was no indication on this form that Resident #130 refused care or that several attempts were made to clip his nails. There were no other sheets to detect if nail care was attempted or refused.</p> <p>Interview on 03/07/14 at 4:25 Pm with the DON and Consultant Nurse revealed Nurse #2 clipped the resident's nails. The expectation was that nails were cut on shower days and as needed. If a resident refused then the nurse should document the refusal in the medical record. The next shift was expected to approach the resident</p>	F 312			

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F 312	Continued From page 21 regarding the care that was refused and again document any refusals.	F 312			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the chair alarm for two days of the survey as care planned for 1 of 3 sampled residents reviewed for accidents (Resident #130). Findings included: Resident #130 was admitted on 03/26/12. His diagnoses included dementia, diabetes, hypertension and thyroid disorder. The most recent Minimum data set, an annual dated 01/20/14, coded Resident #130 with severely impaired cognitive skills, having no behaviors, and requiring extensive assistance with hygiene. He was coded as having no range of motion impairment, and no falls since previous assessment. Review of incident reports revealed Resident #130 last fell on 01/22/14 at 9:00 AM when he tried to stand from his wheelchair and put himself	F 323	F323 _____ 1. Corrective action was accomplished for the alleged deficient practice by the DON assessing resident #130 to ensure alarms were in place according to the care plan on 03-07-14. 2. Residents utilizing personal alarms as safety interventions are also at risk related to this alleged deficient practice. The DON, ADON, or Unit Manager will complete an audit of these residents by 4-4-14 to verify appropriate placement of care planned alarms. 3. Nursing staff will be re-educated regarding placement of care planned safety interventions including the placement of personal alarms. The DON, ADON or Unit Manager will randomly observe 10 residents 3 times per week for	3/31/14	

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F 323	<p>Continued From page 22</p> <p>to bed. His chair alarm sounded at that time.</p> <p>The Care Area Assessment (CAA) dated 01/30/14 for falls stated the resident had weakness and an unsteady gait and needed assist with transfer and mobility.</p> <p>A care plan was initiated due to his risk for falls on 04/13/12. This care plan was last updated 01/28/14. Interventions to meet the goal to have no fall related injuries included the use of a bed alarm and chair alarm.</p> <p>Resident #130 was observed sitting in his wheelchair in his room, sleeping, on 03/04/14 at 1:45 PM without any alarm. At this time, staff assisted him to bed, no alarm sounded when he was transferred and no alarm was observed in the wheelchair.</p> <p>Observations of Resident #131 being in his wheelchair, in his room, with no alarm in place occurred on 03/05/14 at 8:55 AM, at 9:57 AM, at 11:17 AM, and at 12:11 PM.</p> <p>Review of the nurse aide assignment sheet dated 03/05/14, which instruct nurse aides on residents' individual care, noted Resident #130 was to have bed and wheelchair alarms on.</p> <p>On 03/06/13 at 8:13 AM, Resident #130 was up in his chair with a clip type alarm in place on a shelf located on the back of his wheelchair. Interview with Nurse Aide (NA) #3 revealed Resident #130 was gotten up on night shift.</p> <p>Interview with Nurse #2 on 03/06/14 at 9:05 AM revealed he checked for the placement of an alarm daily and Resident #130 was usually in bed</p>	F 323	<p>4 weeks, then weekly for 8 weeks to verify placement of personal alarms.</p> <p>4. The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 323	Continued From page 23 when he checked for alarms being in place. When asked if the nurse checked for an alarm when the resident was in the wheelchair, he stated he tried. He did not comment on the missing wheelchair alarm for the past two days. Interview with the Director of Nursing on 03/07/14 at 4:25 PM revealed the alarm was expected to be on the resident when he was in his wheelchair. She stated that the nurses were expected to check alarm placement within the first 2 hours of the start of their shift and document the alarm was on in the medication administration record. If the resident was in bed, then the alarm check would refer to the bed alarm.	F 323			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility medication error rate was greater than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.4% for 1 of 6 residents observed during medication pass. (Resident #112). Findings included: Resident #112 was admitted to the facility 01/25/14 with diagnoses which included chronic obstructive pulmonary disease and hypertension.	F 332	F332 1. 1. Corrective action was accomplished for the alleged deficient practice by the DON completing a Medication Variance for Resident #112 regarding the medication dosage labeling and administration of the inhaler. The Nurse responsible for this error received individual education by the DON, regarding the Five Rights of medication administration including verification of	3/31/14	

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F 332	<p>Continued From page 24</p> <p>A review of Resident #112's medical record revealed physician orders dated March 1, 2014 through March 30, 2014 for the following inhalers: Advair Diskus inhalation 250-50 microgram dose 1 puff twice a day and Spiriva Handhaler inhalation capsule 18 micrograms 1 inhalation once a day. Further medical record review revealed a physician's order dated 02/27/14 for Metoprolol Tartrate oral tablet 25 milligrams 1 tablet by mouth twice a day.</p> <p>Nurse #3 was observed on 03/05/14 at 8:22 AM preparing and administering Resident #112's medications.</p> <p>a. Nurse #3 was observed checking Resident #112's medication administration record against prepared packets of medication. When she observed the packet containing Metoprolol Tartrate, no medication dosage could be found on the packet. Nurse #3 was observed administering the medication without further investigation.</p> <p>b. Nurse #3 was observed administering the Spiriva Handhaler via inhalation then immediately administering the Advair Discus inhaler. There was no waiting period between the 2 inhalers.</p> <p>An interview with Nurse #1 on 03/05/14 at 8:32 AM revealed she administered medications on this hall frequently. She stated until today, she had not noticed the dosage of Metoprolol Tartrate was not provided on the medication packet. Further interview with Nurse #1 revealed she usually waited 3 minutes between administering inhalers. She acknowledged she gave one</p>	F 332	<p>dosages and techniques for inhaler administration by 4-4-14.</p> <p>2. All residents receiving administration of medication via an inhaler have the potential to be affected by the same alleged deficient practice.</p> <p>3. Licensed Nurses and Certified Medication Aides were re-educated by the DON or Designee regarding the Five Rights of Medication Administration to include verification of dosage prior to administration and techniques for administration of inhalers. This re-education will be completed by 04-04-14. The DON, ADON, Unit Manager or designee will randomly observe 5 medication passes 3 times per week for 4 weeks then weekly for 8 weeks to verify accurate administration of inhalers.</p> <p>4. The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 332	Continued From page 25 inhaler followed by the other without waiting. An interview with the Director of Nursing (DON) on 03/05/14 at 11:29 AM revealed she expected inhalers to be administered waiting at least 1 minute between doses. The DON added she expected nurses to ensure the dosage of medications administered was in accordance with the physician's order.	F 332			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		3/31/14	

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F 356	<p>Continued From page 26</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to post the correct dates for the required nursing staff information for 5 of 5 days (03/03/14 through 03/07/14).</p> <p>Findings included:</p> <p>On 03/03/14 at 9:45 AM on a board; to the right, upon entrance to the facility, an observation of the required nursing staff information data was posted with a date of 02/28/14. On 03/03/14 at 2:33 PM an observation of the required nursing staff information data remained posted with a date of 02/28/14.</p> <p>On 03/04/14 at 7:45 AM an observation of the board upon entrance to the facility revealed the required nursing staff information data posted with a date of 03/03/14. On 03/04/14 at 12:43 PM an observation of the posted nursing staff information data remained posted and was dated for 03/03/14.</p> <p>Observations on 03/05/14 at 1:12 PM, 03/05/14 at 3:38 PM, and 03/05/14 at 5:03 PM revealed the posted nursing staff information data was dated for 03/04/14.</p> <p>Observations on 03/06/14 at 12:23 PM and 03/06/14 at 1:45 PM revealed the posted nursing staff information data was dated for 03/05/14.</p>	F 356	<p>F356_____</p> <ol style="list-style-type: none"> 1) The receptionist corrected the nurse staffing data information to reflect the current information on 3/8/14 2) All residents have the potential to be affected by this alleged deficient practice. 3) The Administrator and Director of Nursing were re-educated regarding the daily staffing posting requirements by the Regional Clinical Director by 04-04-14. The Administrator or Director of Nursing will audit the daily staffing posting 3 times per week for 4 weeks, then weekly for 8 weeks to ensure posting is timely and accurate. Opportunities will be corrected as identified 4) The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. 		

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F 356	Continued From page 27 Observations on 03/07/14 at 7:58 AM, 03/07/14 at 11:43 AM, 03/07/14 at 12:48 PM, and 03/07/14 at 2:38 PM revealed the posted nursing staff information data was dated for 03/06/14. On 03/07/14 at 4:31 PM an interview was conducted with the Director of Nursing. She indicated her expectation for the required nursing staff information data was to be posted with the correct dates by 12 noon each day Monday through Friday. She further indicated she was unaware the required nursing staff information data was to be posted on the weekends.	F 356			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed to serve hot food and food which was appetizing and attractive in appearance for 3 of 3 residents reviewed for food palatability (Resident #82, #123, and #119). Findings included: 1. Resident #82 was admitted to the facility on 01/01/14 with diagnoses which included subdural hemorrhage, muscle weakness, chronic kidney disease, and post cerebral vascular accident.	F 364	F364 _____ 1. Corrective action was accomplished for the alleged deficient practice by the Dietary Manager interviewing residents regarding palatable food including acceptable temperature when meals are served and meals that are appetizing and attractive in appearance by 04-04-14.	3/31/14	

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F 364	<p>Continued From page 28</p> <p>The admission Minimum Data Set (MDS) dated 01/08/14 coded the resident with being cognitively intact, requiring extensive assistance with most activities of daily living (ADL), and being non-ambulatory. Resident #82 was able to eat without assistance after the meal tray was set up.</p> <p>An interview was conducted with Resident #82 on 03/04/14 at 11:30 AM. The resident stated the breakfast was always cold, especially the eggs.</p> <p>An observation on 03/05/14 at 8:00 AM of the breakfast tray line revealed the oatmeal and grits were pre-scooped into non-heated bowls, covered with a plastic lid, and placed on a shelf above the tray line away from the heat. These bowls would set on the shelf until placed onto the resident's tray.</p> <p>On 03/05/14 at 8:03 AM a breakfast test tray was requested.</p> <p>On 03/05/14 at 8:53 AM the test tray left the kitchen in an aluminum tray cart in route to the 100 hall.</p> <p>On 03/05/14 at 8:54 AM the first tray was delivered to a resident's room and Nurse Aide (NA) #1 set up the tray for the resident.</p> <p>On 03/05/14 at 9:18 AM the last breakfast tray was delivered to a resident's room and NA #1 set up the tray for the resident.</p> <p>On 03/05/14 at 9:19 AM received breakfast test tray from the tray cart. The breakfast test tray consisted of scrambled eggs, sausage patty, 2 pancakes, and bowl of grits. The butter was</p>	F 364	<p>2.All residents have the potential to be affected by the same alleged deficient practice; therefore, alert and oriented residents were interviewed by the Dietary Manager regarding the palatability of their food between March 7th and March 10th 2014.</p> <p>3.Measures put into place initiated to ensure that the alleged deficient practice does not recur include:</p> <p>a. Nursing and Dietary staff will be re-educated by the Dietary Manager or designee, regarding the importance of palatability of food related to timely tray service and food temperatures.. If food temperatures are not acceptable per individual resident choice, item will be offered to be re-heated to meet resident preference. This education will be completed by 4-4-14.</p> <p>b. Air handling units in the kitchen will repaired to reduce drafts of cool air that were affecting food temperatures prior to tray service by 4-4-14.</p> <p>b. Resident council meeting conducted on March 27, 2014 to include review of F364 citation w/council approval of interventions.</p> <p>c. The Dietary Manager or designee will interview 10 alert and orientated residents a week to be preformed weekly for 12 weeks to verify palatability of meals served.</p> <p>4. The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The</p>		

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F 364	<p>Continued From page 29</p> <p>observed not to melt on the pancakes or on the grits.</p> <p>On 03/05/14 at 9:21 AM, Surveyor and NA #1 tasted the eggs, sausage patty, pancakes, and grits. The breakfast items on the test tray were cold.</p> <p>On 03/05/14 at 9:25 AM an interview with NA #1 was conducted. She stated the breakfast items she tasted were cold. She further stated most of the time the residents complained their meals were cold. She indicated she re-heated their food in the microwave or would take the meal tray back to the kitchen for an alternate.</p> <p>On 03/07/14 at 9:58 AM an interview was conducted with the Activity Director (AD). She revealed over the last several months, the former Administrator had conducted the Resident Council Meetings. The AD stated she was present at the 01/29/14 meeting and she recalled food temp issues being discussed. She further stated the discussion was related to the food not being warm and the complaints were voiced from residents that ate in their rooms. The AD indicated the residents who expressed concerns were encouraged to eat in the dining room where the food came straight from the kitchen. She further indicated she was unaware of how the concern was handled.</p> <p>On 03/07/14 at 10:00 AM Resident #82's family was interviewed. The family member stated they had a care plan meeting a couple of weeks ago and complained about the food being cold.</p> <p>On 03/07/14 at 3:55 PM an interview was conducted with the Dietary Manager (DM). She</p>	F 364	<p>QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 364	<p>Continued From page 30</p> <p>revealed she was unaware of the concerns related to food temperatures and would check with the former Administrator to find out what was said in the meeting. She further stated she was unaware of any food temperature concerns except in October 2013 when the food pallet heater went out and needed to be replaced. Review of the October 2013 Resident Council meeting notes and October 2013 grievance log revealed no complaints of cold food in October 2013.</p> <p>Review of the grievance log for the prior 6 months revealed 3 grievances filed by residents involving the taste and temperature of the facility food. Response recorded for each grievance was the dietary manager was notified of the complaints and would follow the procedures to make improvements.</p> <p>Review of the minutes of Resident Council Meetings for the prior 3 months revealed food palatability concerns were identified on 01/29/14 related to "food temp." Further review of the minutes revealed concerns were identified on 02/25/14 related to "stale sandwiches, cold foods, and residents requested a food committee meeting." There were no specifics and/or any other information noted of the forms.</p> <p>2. Resident #123 was admitted to the facility on 12/23/13 and was readmitted on 02/07/14 after a hospitalization. Resident #123's diagnoses included metabolic encephalopathy, acute chronic renal failure, and Parkinson's disease.</p> <p>The admission Minimum Data Set (MDS) dated</p>	F 364			

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F 364	<p>Continued From page 31</p> <p>12/30/13 coded the resident cognitively intact, having no behaviors, requiring extensive assistance with hygiene and having no falls since admission.</p> <p>An interview was conducted with Resident #123 on 03/03/14 at 2:20 PM. He stated he wanted hotter foods. He stated all the meals were cold and he would eat in the dining room sometimes and other times in his room.</p> <p>On 03/04/14 at 8:41 AM Resident #123 was observed eating his breakfast in his room. He stated the breakfast was cold.</p> <p>On 03/06/14 at 5:11 PM Resident #123 stated he had received cold food again.</p> <p>On 03/07/14 at 9:58 AM an interview was conducted with the Activity Director (AD). She revealed over the last several months, the former Administrator had conducted the Resident Council Meetings. The AD stated she was present at the 01/29/14 meeting. She stated as she recalled, the food temp issues related to food was not warm and the residents with the concerns mostly ate in their rooms. The AD stated the residents who expressed concerns were encouraged to eat in the dining room where the food came straight from the kitchen. She further indicated she did not know how the concern was handled.</p> <p>On 03/07/14 at 3:55 PM an interview was conducted with the Dietary Manager (DM). She revealed she knew nothing about the concerns related to food temperatures and would try to check with the former Administrator to find out what was said in the meeting. She further stated</p>	F 364			

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F 364	Continued From page 32 she has been unaware of any food temperature concerns except in October 2013 when the food pallet heater went out and needed to be replaced. Review of the October 2013 Resident Council meeting notes and October 2013 grievance log revealed no complaints of cold food. Review of the grievance log for the prior 6 months revealed 3 grievances filed by residents involving the taste and temperature of the facility food. Response recorded for each grievance was dietary manager was notified of the complaints and would follow the procedures to make improvements. Review of the minutes of Resident Council Meetings for prior 3 months revealed food palatability concerns were identified on 01/29/14 related to "food temp." Further review of the minutes revealed concerns were identified on 02/25/14 related to "stale sandwiches, cold foods, and residents requested a food committee meeting." There were no specifics and/or any other information noted of the forms.	F 364			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		3/31/14	

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F 425	<p>Continued From page 33</p> <p>administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and pharmacy and facility staff interviews, the facility failed to provide the dose of a medication on packets containing Metoprolol Tartrate for 1 of 6 residents observed on medication pass (Resident #112).</p> <p>Findings included:</p> <p>Resident #112 was admitted to the facility 01/25/14 with diagnoses included chronic obstructive pulmonary disease and hypertension.</p> <p>A review of Resident #112's medical record revealed a physician's order dated 02/27/14 for Metoprolol Tartrate 25 milligrams (mg) 1 tablet by mouth twice a day.</p> <p>A medication administration observation was conducted on 03/05/14 at 8:22 AM. Nurse #3 was observed checking Resident #112's medication administration record against prepared packets of medication. The packet containing Metoprolol Tartrate was observed. The packet contained Resident #112's name and room number, date and time medication to be administered, and</p>	F 425	<p>F425 _____</p> <p>_____</p> <ol style="list-style-type: none"> 1. Resident #112 medications have been reviewed by the pharmacist to ensure all medications dispensed are accurate. 2. All residents have to the potential to be affected by this alleged deficient practice.. The Pharmacy General Manager or designee will conduct an audit of all residents receiving Metoprolol to verify accurate dosage labeling by 4-4-14. 3. The Pharmacy General Manager or designee will re-educate the pharmacy staff on proper procedures for medication labeling during all steps of the dispensing process by 04-04-14. The Pharmacy General Manager or designee will perform random audits 3 times per week for 3 weeks and weekly for 12 weeks to verify proper labeling procedures. Opportunites 		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2014
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABILITATION/STATESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 520 VALLEY STREET STATESVILLE, NC 28677		
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F 425	Continued From page 34 name of the medication. No medication dosage was observed. An interview with Nurse #1 on 03/05/14 at 8:32 AM revealed she administered medications on this hall frequently. She explained the facility pharmacy delivered medications to the facility in packets labeled with the medication name and dosage, the resident's name, and date and time medication was to be administered. Nurse #1 stated until today, she had not noticed the lack of dosage on the packet containing Metoprolol Tartrate. An interview was conducted via phone with the facility pharmacy General Manager #1 on 03/05/14 at 11:14 AM. The general manager stated the pharmacy had recently started receiving Metoprolol Tartrate 25 mg from a different vendor. He explained the pharmacist that entered this medication into the pharmacy computer failed to enter the dosage of 25 mg along with the medication name. The information on the medication packets was provided from the pharmacy computer then distributed to the facility. From the numbers printed on the Metoprolol Tartrate tablets, General Manager #1 identified the dosage of the tablet as 25 mg. General Manager #1 stated the dosage of the Metoprolol Tartrate should have been on the medication packet.	F 425	will be corrected as identified. 4. The results of these audits and interventions will be submitted to the QAPI Committee by the Consulting Pharmacist or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.		
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	F 431		3/31/14	

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F 431	<p>Continued From page 35</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired Lantus insulin from 1 of 6 medication carts.</p> <p>Findings included: A review of manufacturer's instructions for Lantus</p>	F 431	<p>F431 _____</p> <p>1. Corrective action was accomplished for the alleged deficient practice by the Director of Nursing discarding the expired insulin vial on 03-07-10</p>		

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F 431	<p>Continued From page 36</p> <p>insulin indicated vials must be discarded 28 days after opening.</p> <p>During an observation on 03/07/14 at 11:17 AM, an open vial of Lantus insulin marked with an expiration date of 02/24/14 was found on the 200 hall medication cart. Nurse #2 confirmed the vial was utilized nightly for Resident #109 and was the only vial of Lantus insulin in the cart for this resident. Nurse #2 also confirmed the expiration date written on the vial was 02/24/14. Nurse #2 explained when insulin was documented in the computer as administered, a drop down box appeared. He stated the nurse administering the medication was supposed to write the expiration date in this drop down box.</p> <p>An interview with Nurse #1 was conducted on 03/07/14 at 11:25 AM. Nurse #1 confirmed by pulling up computer insulin administration records for Resident #109 that the Lantus insulin had been documented as utilized nightly the entire month of February 2014 with the last dosage administered on the evening of 03/06/14. Nurse #1 stated the third shift nurse was responsible for checking expiration dates on insulin containers. She added if the insulin was past the expiration date, the vial was to be discarded and replaced with an unopened vial. Nurse #1 stated the nurse administering the insulin should observe the expiration date and not use it if the medication was expired.</p> <p>An interview with the Director of Nursing (DON) was conducted on 03/07/14 at 5:13 PM. The DON confirmed the third shift nurse should be checking insulin expiration dates on insulin vials in the medication carts. She stated expired insulin should be replaced with a new vial. The DON</p>	F 431	<p>2. Residents who require insulin have the potential to be affected by the same alleged deficient practice. The DON, ADON and Unit Managers completed an inspection of all medication carts on 03-07-14 for unlabeled, undated or expired medications and items with discrepancy were discarded. .</p> <p>3. Measures put into place or system changes initiated to ensure that the alleged deficient practice I does not recur include: Licensed Nurses were re-educated by the DON or Designee on the process for dating, labeling and storing medications, this education was completed by 04-04-14 The DON, ADON or Unit Manager will randomly audit medication carts 3 times per week for 4 weeks and then weekly for 8 weeks to validate accurate dating, labeling and storage of medications. Opportunities will be corrected as identified.</p> <p>4. Measures to ensure that corrections are achieved & sustained include: The results of these audits and interventions will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed.</p>		

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F 431	Continued From page 37 expected nurses to check insulin expirations dates and not administer expired medications.	F 431			