STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(A) BUILDING ____________________________

(B) MULTIPLE CONSTRUCTION B. WING ____________________________

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & RETIREMENT/MONROE

ADDRESS, CITY, STATE, ZIP CODE
204 OLD HIGHWAY 74 EAST
MONROE, NC  28112

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
F 281 SS=D 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 record review and staff interview the facility failed to follow physician orders for medication administration for 1 of 6 sampled residents (Resident #53).

The findings included:

Resident #53 was admitted to the facility on 12/6/13 with diagnoses that included Parkinson’s disease, Hypertension, dementia, Alzheimer’s disease, depression and suicide attempt. The annual Minimum Data Set (MDS) assessment dated 12/21/15 revealed Resident #53 was cognitively intact as evidenced by a BIMS score of 13. The resident mood interview revealed a score of 11 indicating Resident #53 was moderately depressed as evidenced by feeling down, depressed, and hopeless; feeling tired or having little energy; and thoughts the he would be better off dead or of hurting himself in some way. Review of Resident #53’s Care Plan Dated 12/14/15 revealed a problem of Depression. Indicators of altered mood stated suicide attempt related to the diagnosis of Depression. The Goal stated Resident #53 would have indicators of altered mood decreased to no more than 1 episode per week through next review. The approaches include review drug regime and possible interaction; and notify medical doctor as needed.

Review of Resident #53’s Care Plan dated 12/23/15 revealed Resident #53 was at risk for altered psychosocial needs and social isolation

Criteria 1
On 1/3/16 the MDS Coordinator identified and corrected a transcription error related to Remeron ordered 12/29/15. Resident #53 began receiving the Remeron dose as ordered on 1/3/16. A Medication Variance Form was completed by the ADON on 1/7/16. The nurse responsible for failing to complete the transcription was counseled by the Director of Nursing on 1/12/16.

Criteria 2
All residents have the potential to be affected by the alleged deficient practice. On 1/22/16 the Director of Nursing, Assistant Director of Nursing and the Unit Manager completed an audit of all the physician’s orders received during the last 30 days to validate transcription.

Criteria 3
The Director of Nursing and Assistant Director of Nursing re-educated all licensed nurses on the facility policy for transcribing physician’s orders. This education to be complete on 1/28/16. The Director of Nursing, Assistance Director of Nursing or the Unit Manager will audit carbon copies of physician’s orders 5 times per week for 4 weeks, then weekly

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE
Electronically Signed

DATE
01/28/2016

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.
BRIAN CENTER HEALTH & RETIREMENT/MONROE

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B. WING _________________________

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BRIAN CENTER HEALTH & RETIREMENT/MONROE

STREET ADDRESS, CITY, STATE, ZIP CODE

204 OLD HIGHWAY 74 EAST
MONROE, NC  28112

IDENTIFICATION NUMBER:

345345

DATE SURVEY COMPLETED

01/07/2016

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

Event ID: F2FI11

Facility ID: 922987

If continuation sheet 2 of 8
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

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STREET ADDRESS, CITY, STATE, ZIP CODE

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MONROE, NC 28112

(4) ID PREFIX TAG

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

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(5) COMPLETION DATE

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assessment. She indicated she communicated
the variance to the ADON that Resident #53
Remeron ordered 12/29/15 was not transcribed to
the December 2015 MAR and began on January
2016 MAR.

In a continued interview with ADON on 1/7/15 at
4:30 pm indicated she did not recall having a
conversation about the medication variance in
regards to Resident #53’s physician ordered
Remeron for depression.

Interview with the Director of Nursing (DON) on
1/7/15 at 4:22 pm revealed physician orders were
flagged in resident medical records to identify an
order was provided by the physician. Nursing
was to transcribe physician orders to the MAR
and fax the physician order to the pharmacy. The
pharmacy receives the order and provides the
medication to the facility. The DON indicated
Resident #53 had a physician order dated
12/29/15 for Remeron. During an observed the
MAR for the December 2015 and January 2016
the DON revealed Remeron it had not been
administered to Resident #53 until January 3,
2016. The DON revealed a medication variance
form should have been completed by the nurse
who identified the error. The DON stated her
expectation was that nursing contact the
pharmacy to identify why the medication was not
delivered. The DON indicated she further
expected nursing to utilize the Pixus (on site
medication dispenser) to determine if the
medication was on site. A medication Variance
report was not completed. The DON indicated
she was unaware Resident #53 did not receive
Remeron 15mg ordered on 12/29/15 until today
(1/7/15).

F 282

SS=D

483.20(k)(3)(ii) SERVICES BY QUALIFIED
PERSONS/PER CARE PLAN

1/28/16
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview the facility failed to follow interventions as indicated on the care plan for 1 of 10 sampled residents (Resident #53) who had an intervention for alternate means of requesting assistance to prevent further suicide attempts.

The findings included:
Resident #53 was admitted to the facility on 12/6/13 with a diagnoses that included Parkinson's disease, Hypertension, dementia, Alzheimer's disease, depression and suicide attempt. The annual Minimum Data Set (MDS) assessment dated 12/21/15 revealed Resident #53 was cognitively intact as evidenced by a BIMS score of 13. The resident mood interview revealed a score of 11 indicating Resident #53 was moderately depressed as evidenced by feeling down, depressed, and hopeless; feeling tired or having little energy; and thoughts he would be better off dead or of hurting himself in some way.

A review of Resident #53's nurse's note written by RN#1 at 3:00 pm dated 12/11/15 stated, "Resident stated to this nurse (nurse #1)  " I've been trying to kill myself and just can't get it right " this nurse did try to comfort resident and periodically checked on resident. CNA went into resident's room approximately 2:30pm and observed resident with cord to call light wrapped around his neck trying to strangle himself. Resident states " he wants to die " immediately

Criteria 1
On 1/6/16 the Director of Nursing validated and implemented the care planned interventions for resident #53. On 1/7/16 the Nursing Assistant Care Guide for resident #53 was updated to reflect care planned interventions.

Criteria 2
All suicidal residents have the potential to be affected by the alleged deficient practice. On 1/7/16 the Director of Nursing, Assistant Director of Nursing and Unit Manager completed an audit of care plans for all suicidal residents, to validate interventions are in place and documented on the Care Plan and the Nursing Assistant Care Guide.

Criteria 3
All nursing staff were re-educated by the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator regarding implementation of care planned interventions and the use of the Nursing Assistant Care Guide to communicate care planned interventions. This education was complete on 1/12/16. The Director of Nursing, Assistant Director of Nursing and Unit Manager will
**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID** | **PREFIX** | **TAG** | **DESCRIPTION**
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F 282 | | | Continued From page 4 called doctor. Received order to send to ER (emergency room) RP (responsible party) aware police arrived at 1445 EMS (emergency medical services) at 3:15pm. Resident left facility at 3:30pm ".

Review of Resident #53’s physician order dated 12/11/15 stated send to hospital emergency department related suicidal ideations with attempt.

Review of Resident #53’s care plan Dated 12/14/15 revealed a problem of Depression. Indicators of altered mood stated suicide attempt related to the diagnosis of Depression. The goal stated Resident #53 would have indicators of altered mood decreased to no more than 1 episode per week through next review. The approaches included review drug regime, possible interactions, notify MD as needed and remove call bell with cord from reach. Resident #53 was provided a cow bell to ring for assistance.

Interview with Nurse (RN#1) on 1/6/15 at 10:36am revealed on the morning of 12/11/15 she went into Resident #53’s room to give medications. RN#1 indicated when she inquired about how Resident #53 was doing Resident #53 indicated he wasn’t feeling well. RN#1 stated, "He said that he was trying to kill himself but can’t get it right "... Resident #53 further stated he tired the bag but couldn’t get it right. RN#1 indicated she took the trash bag out of the room and told the Director of Nursing (DON). The DON revealed the DON communicated that Resident #53 had attempted before. RN#1 revealed that was her first time becoming aware of Resident #53’s previous incident to commit suicide. The DON told RN#1 to monitor Resident #53 regularly. RN#1 described the monitoring to be increased to every 30 minutes. The DON stated randomly audit 10 resident care plans weekly for 12 weeks to validate accurate documentation and implementation of care planned interventions. Opportunities identified will be corrected weekly by the Director of Nursing, Assistant Director of Nursing or Unit Manager.

Criteria 4 The results of these audits will be reported by the Director of Nursing monthly to the QAPI Committee and the committee will make recommendations for further actions needed.
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<td>that later in her shift NA#1 came running down the hall and said Resident #53 had the cord from the call light wrapped around his neck. Following the incident the medical doctor was notified. The Police and EMS (emergency medical services) were contacted. Nursing stayed with Resident #53 until he was sent out with emergency services. Interview with Nursing Assistant (NA) #1 on 1/6/15 at 10:54 am revealed on 12/11/15 she observed Resident #1’s call light to be on. NA#1 couldn’t recall the exact time she observed Resident #53 looping the cord around his neck but estimated 1:00 to 1:30pm due to her recalling making her second rounds and resident #53 eating lunch. NA#1 stated she knocked on Resident #53’s door and entered the room to discover Resident #53 to be looping his call bell around his neck. NA#1 indicated when she inquired why Resident #53 was putting the call bell cord around his neck, Resident #53 stated he was trying to kill himself. NA#1 indicated she removed the cord from around Resident #53 neck and ran to tell RN#1 what had occurred. NA#1 stated she was never informed prior to her shift on 12/11/15 that Resident #53 had communicated that he wanted to harm himself. NA#1 indicated it was communicated to her upon hire that the resident had had an attempt to harm himself. NA#1 stated the interventions were to remove sharp objects such as fingernail clippers. NA#1 did not recall being informed about removing plastic bags. NA#1 indicated NA’s became aware of resident needs by viewing a care guide. Review of Resident #1’s care guide revealed resident #53 required total care, was incontinent of bowl and bladder, required Hoyer lift with the use of 2 staff, required a chair cushion, low bed, body alarm and oxygen as needed (PRN).</td>
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### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

BRIAN CENTER HEALTH & RETIREMENT/MONROE

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

204 OLD HIGHWAY 74 EAST
MONROE, NC  28112

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>Observation on 1/6/15 at 11:10 am revealed Resident #53 to be lying in bed. Housekeeping was observed in Resident #53’s room performing housekeeping duties. Resident #53 was observed to have his call bell in his bed within reach. Interview with the assistant director of nursing (ADON) on 1/6/15 at 11:12 am revealed she and the unit manager were responsible for updating resident care guides for NA’s. The ADON revealed a care guide for Resident #53 located in black binder. The care guide in the black binder contained a care guide for Resident #53 that indicated a cow bell would be used in place of the call bell. The ADON indicated the care guide included the intervention of the cow bell and the removal of the call bell was not provided to NA’s due to NA’s not being in-serviced on the new care guide book. The ADON indicated staff were going to be in-serviced on the use of the care guide book (black binder containing care guides) on Tuesday (1/12/16). The care guides NA’s were currently using to identify resident #53’s needs did not have interventions in regards to preventing suicide attempts. The ADON indicated the facility had put interventions in place to include taking Resident #53 nebulizer out of a bag and placing it in a plastic tub, removing the call bell from reach, providing the resident with a cow bell, and moving the resident to a room closer to the nursing station. Interventions should have been included in Resident #53’s care plan and care guide. Interview with the DON on 1/16/15 at 11:37am revealed she was under the impression that Resident #53’s care plan was updated. It was her expectation that Resident #53 care plan have interventions in regards to preventing suicide attempts.</td>
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Interview with the MDS coordinator on 1/7/15 at 4:02 pm revealed she the ADON and Unit coordinator were responsible for updating resident care guides utilized by NA’s. The MDS coordinator indicated she was responsible for updating care plan update dated 12/14/15. She indicated she did not include 1:1 supervision to the updated care plan of 12/14/15 due to resident #53 being hospitalized following the event and 1:1 supervision wasn’t required. MDS coordinator further indicated Resident #53 had not had another suicide attempted following readmission for 1:1 supervision to be added or carried over from care plan dated 6/7/15. The MDS coordinator revealed other than “removed call bell with cord from reach, Gave cow bell to ring for assistance ”, no other intervention were added to the care plan.