STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING ______ B. WING ______	C 12/09/2016

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BRIAN CENTER HEALTH & RETIREMENT/MONROE	**204 OLD HIGHWAY 74 EAST MONROE, NC 28112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/9/16. Event ID# YG3011.	F 000		
F 253 SS=E	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 observations and staff interviews the facility failed to make repairs to walls, ceilings, cabinet doors, cabinet tabletop and a broken air conditioning vent in 7 out of 38 rooms (rooms 104,107,203,205,207,213 and 215). Findings included: 1. Observation on 12/6/16 at 9:07 AM revealed water stains on the ceiling above the closet in room 215. 2. Observation on 12/6/16 at 10:19 AM revealed water stains on the ceiling above the sink, torn sheet rock on wall under the call light outlet, the right side of the bathroom door with missing sheet rock above the baseboard and torn sheet rock on the wall at the left side of the door to room in room 207. 3. Observation on 12/6/16 at 11:10 AM revealed water stains on ceiling above the sink and 2 small pieces of tile missing from the bathroom floor and sanded sheet rock under the light fixture with no paint in room 107. 4. Observation on 12/6/16 at 11:26 AM revealed the enteral feeding pole to be leaning and loose and enforced with tape (wound care tape) at the	F 253	1. Maintenance Director repaired and painted water stains on ceiling above the closet in room 215. Completed 12/30/16. 2. Maintenance Director repaired and painted water stains on the ceiling above the sink in room 207 and repaired the sheet rock on the wall, sanded and painted under the call light outlet and all other walls in room 207. Completed 12/29/16. 3. Maintenance Director repaired and painted the water stains on the ceiling above the sink in room 107, installed new flooring in the bathroom, repaired the sheet rock, sanded and painted under the light fixture. Completed 12/30/16. 4. Maintenance Director repaired the enteral feeding pole in room 104 and removed the wound care tape from the bottom of the pole where it meets the support base. Completed 12/30/16.	1/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/04/2017

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 253	Continued From page 1 bottom of the pole where the pole meets the support base in room 104. 5. Observation on 12/6/16 at 2:28 PM revealed water stains on the ceiling above bed 2 in room 213. 6. Observation on 12/6/16 at 3:29 PM revealed the left cabinet door under the sink to hang loose from the top hinge and laminate edging loose from the top of the left side of the bedside table in room 205. 7. Observation on 12/6/16 at 3:56 PM revealed the air conditioning unit with missing and broken vent, baseboard under sink loose from the wall in room 203. An interview with nurse aide #1 on 12/9/16 at 10:10 AM revealed that if any repairs were needed for resident rooms or equipment she wrote it in the book located at the nurse ' s station. She stated it was a book with work orders that could be filled out for maintenance to repair. She stated she was not aware of any repairs that were needed at that time. During an interview with housekeeping aide #1 on 12/9/16 at 10:15 AM revealed that if any repairs were needed in resident rooms, she wrote it down on the work order forms located at the nurses station so that maintenance could make the repairs. An interview with nurse #1 on 12/9/16 at 10:20 AM indicated that any staff member could fill out work orders for communication to maintenance to make the repairs. If it was an emergency or off hours then maintenance director was called and he responded. She stated she was not aware of any repairs needed at that time for resident rooms or equipment. During a second observation with the maintenance director on 12/9/16 at 10:30 AM confirmed the following:	F 253	5. Maintenance Director repaired and painted the ceiling above bed 2 in room 213. Completed 1/02/17. 6. Maintenance Director replaced all worn cabinet door hinges in room 205 and ordered new bedside tables for the room. Completed 1/02/17. 7. Maintenance Director replaced the broken air conditioner vent and replaced the PTAC unit in room 203 and replaced the baseboard under the sink that was loose from the wall. Completed 12/20/16. Criteria #2 All resident have the potential to be affected by this alleged deficient practice. Detailed maintenance rounds have been conducted by the NHA and Maintenance Director and a prioritized list of repairs has been developed for ongoing repairs and maintenance, completed 12/26/16. Water stains on ceiling tiles were cause by leaks in the sprinkler system. Leaks have been repaired, completed on 1/25/16, 2/10/16, 2/17/16, 4/20/16, 8/4/16, 8/13/16, 9/11/16, 10/10/16 and 11/25/16. Criteria #3 Facility staff will be re-educated by the SDC on the process for completion of the Maintenance Request Form for	

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F 253	Continued From page 2 1. Room 215- The maintenance director stated he was not aware of the water stains on the ceiling above the closet. 2. Room 207- The maintenance director stated he was not aware of the water stains on the ceiling above the sink or torn sheet rock on the wall under the call light outlet, the wall on the right side of the bathroom door or the wall on the left side of the door to the room. 3. Room 107- The maintenance director stated he was not aware of water stains on the bathroom ceiling, 2 small areas of missing floor tile in the bathroom and sanded sheet rock under light fixture with no paint. 4. Room 104- The maintenance director stated he was not aware the enteral feeding pole needed repair, he indicated if it just needs to be tightened up, and he could do that. 5. Room 213- The maintenance director stated he was not aware of water stained ceiling tile above bed 2. 6. Room 205- The left cabinet door under the sink was hanging loose from the top hinge and laminate edging was loose from the top of the left side of the bedside table. The maintenance director stated he was not aware that the items needed repair. 7. Room 203- The maintenance director stated he was not aware of the needed repair to the air conditioning vent and loose baseboard under the sink. During an interview with the maintenance director on 12/9/16 at 10:30 AM he revealed that he depended on work orders to make needed repairs. He stated he did room checks randomly every morning and if repairs are needed he made those repairs at that time. He stated he also checked the rooms before new admissions came for any needed repairs.	F 253	notification to the Maintenance Department for needed facility repairs. This re-education was completed by 1/6/17. The NHA and Maintenance Director will conduct facility rounds weekly for 12 weeks to validate completion of needed repairs and maintenance as outlined on the prioritized maintenance list. Criteria #4 The results of these audits and monitoring will be submitted to the QAPI committee by the Maintenance Director for review by the IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.	

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F 253	Continued From page 3 An interview with the administrator on 12/9/16 at 11:35 AM indicated that he had managers assigned to 4 to 5 rooms to check rooms daily called the Ambassador program. He stated he was his expectation for the ambassadors to report their findings to the maintenance director in daily morning meeting each morning. He explained the managers had been educated by staff development on what to look for in resident rooms.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		1/6/17

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F 278	Continued From page 4 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code Section B of the Minimum Data Set (MDS) in the areas of speech clarity, and the ability to be understood and understand for 1 of 17 residents (Resident #78) and failed to accurately code PASRR (Preadmission Screening Resident Review) on the MDS (Minimum Data Set) for one of 17 residents (Resident #70). The findings included: 1. Resident #78 was admitted on 8/22/16 with diagnoses that included intra cranial injury, and chronic respiratory failure. Review of the admission Minimum Data Set (MDS) assessment dated 9/6/16 revealed under the cognitive patterns assessment (Section C) that Resident #78 was rarely or never understood with severely impaired decision making. However Section B of the MDS indicated that resident #78 had clear speech, was understood and could understand others with clear comprehension. Interview with the MDS Nurse on 12/9/16 at 11:00 AM revealed that Resident #78 was non communicative due to traumatic brain injury, did not appear to be understood or understand others and was totally dependent for all his care needs to be met. She stated Under Section B of the MDS, the areas of speech clarity, makes self understood, and ability to understand others had	F 278	1. The MDS for resident #78 with ARD 9/6/16 was corrected on 12/8/16 by the RCMD to reflect accurate speech and understanding. Resident nonverbal and is rarely/never understood. The MDS for resident #70 with ARD 11/30/16 was corrected on 12/8/2016 by the RCMD to reflect the coding of the Level II PASRR. 2. Current residents have the potential to be affected by this alleged deficient practice. MDS Assessments completed during the last 30 days have been reviewed by the IDT to validate accurate coding, with a focus on section B and residents with a Level II PASRR to validate accurate coding. This audit was completed by 1/6/17 and opportunities corrected as identified by the RCMD and MDS Coordinator. Residents with a Level II PASRR have had their most recent MDS assessments reviewed by the IDT to ensure accurate coding of the Level II PASRR status on 12/30/16. Section B of the most recent MDS assessment for all current residents has been reviewed by the IDT to validate accuracy, this was completed on 12/30/16.	

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F 278 Continued From page 5

been inaccurately coded. She added and this must have been a data entry error.

During interview with the Director of Nursing (DON) on 12/9/16 at 1:30 PM, she indicated that Resident #78 did not speak and could not understand or make himself understood. She acknowledged that an MDS indicating Resident #78 could speak clearly and was understood and could understand would be incorrectly coded and further stated that she expected the MDS to be correctly coded.

2. Resident #70 was admitted to the facility on 7/10/15 with diagnoses including major depressive disorder, chronic pain and anxiety disorder. The most recent quarterly MDS dated 10/24/16 assessed him to be cognitively intact. He required supervision with dressing, toileting and eating, limited assistance with bathing and he was independent with transfers, bed mobility and locomotion. The resident was unable to walk.

Review of the Significant Change MDS dated 1/18/16 revealed the following in the PASRR Level II section (A1500): the response to " has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or related condition " was checked " No " and the response to " PASRR Level II Conditions " under the Serious Mental Illness " heading was also checked " No " .

A review of the medical record for Resident #70 revealed a PASRR level II number for the resident with an expiration date of 12/18/16.

An interview was conducted with the Social Worker (SW) on 12/8/16 at 9:04 AM and he

F 278

3. The District Director of Care Management re-educated the RCMD and the MDS Coordinator regarding accurate completion of the MDS related to the assessment of Section B and documentation and coding of the MDS to include the coding of residents with a Level II PASRR. This education was completed by 1/6/17. The IDT will randomly audit 5 completed MDS assessments per week for 12 weeks to validate accuracy with a focus on the coding of Section B. Opportunities will be corrected as identified by the RCMD.

The RCMD was educated by the BOM of location in PCC where she enters PASRR numbers on admission and where to locate the numbers in the admission paperwork. Social worker gave the RCMD current list of PASRR numbers and which ones classify as a level II. Social worker will audit all comprehensive assessments upon completion to ensure accurate coding of PASRR status for 12 weeks, then randomly ongoing.

4. The RCMD will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.

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F 278	Continued From page 6 stated that he did not code the MDS section A1500. He explained he was responsible for renewing PASRR Level II that expire. An interview was conducted with the Business Officer on 12/8/16 at 9:08 AM. She reported she entered PASRR Level II information into the computer system upon a resident admission, but she did not communicate PASRR information to other departments because by entering it into the computer the resident ' s PASRR information was then populated on the face sheet. An interview was conducted with the MDS Nurse on 12/8/16 at 9:13 AM and she reported she was responsible for coding the MDS with PASRR information. She stated she received a list from the SW regarding PASRR Level II status. The MDS Nurse was interviewed again at 11:23 AM on 12/8/16 and she stated that she did not code the MDS A1500 as " yes " due to " human error " . She reported the MDS in progress had been corrected by answering A1500 " yes " .	F 278		
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 reviews and staff interviews: (1) a facility nurse failed to follow the professional standard to administer medications orally as ordered, and instead crushed the medications, mixed them together, and	F 281	1. A medication variance report was completed by the ADON on 12/8/16 for resident #2 regarding the administration route and water flushes. On 12/7/16 the ADON contacted the physician and	1/6/17

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F 281	Continued From page 7 administered them without water flushes via gastrostomy tube for 1 of 1 resident observed during medication administration (Resident #2). Also, (2) a facility nurse failed follow professional standards by not reading physician's orders as documented on the MAR/TAR (Medication Administration Record/Treatment Administration Record) to verify the prescribed rate when administering a continuous tube feeding and bolus water flushes for 1 of 3 residents that had a gastrostomy tube (Resident #78). Findings included: 1. Resident #2 was admitted to the facility on 7/27/16 with diagnosis of acute respiratory failure, quadriplegia and dysphagia. The Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 10/27/16 revealed that Resident #2 was cognitively intact and required extensive assistance with activity of daily living (ADL's). A medication administration observation was conducted for Resident #2 at 9:58 AM on 12/7/16. Nurse #1 was observed to crush, mix together and administer the following medications by the gastrostomy tube: baclofen, a muscle relaxant, 10 milligrams (mg) ½ tablet, aspirin, a pain reliever, 81 mg chewable 1 tablet, diflucan, an antifungal, 100 mg 1 tablet and zinc sulfate, a supplement, 220 mg 1 tablet. Nurse #1 mixed the crushed medications together with 30 milliliters (ml) of water, checked the gastrostomy tube for placement by pushing air into gastric tube and listened for placement. Nurse #1 poured the medications mixed with water in a 60 ml syringe and administered the medications by gravity. Review of Resident #2 ' s medical record revealed a physicians order dated 9/30/16 for baclofen 10 mg ½ tablet by mouth three times a	F 281	reviewed resident #2's medication orders and a new order was received to change the route to via gastrostomy tube and for flushes with medication administration. Nurse #1 received one on one education by the DON on 12/7/16 regarding the medication administration process including the 5 Rights prior to medication administration with a focus on reading and following the physicians order and administering medications via the prescribed route and administration or medications for residents with gastrostomy tubes. A medication variance report was completed by the ADON on 12/8/16 for resident #78 regarding tube feeding rate and water flushes. The enteral feeding rate and water flush rate were verified and the administration corrected by the DON on 12/8/16. Nurse #3 received one on one education by the DON on 12/8/16 regarding the medications administration process including the 5 Rights prior to medication administration with a focus on reading and following the physicians orders and verifying correct enteral feeding rates when administering continuous tube feedings. 2. Current residents have the potential to be affected by this alleged deficient practice. On 12/8/16 the DON and ADON observed current residents receiving continuous enteral feeding to validate feedings were administered at the physicians ordered rate. The DON and ADON conducted an audit of current	

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F 281	Continued From page 8 day, a physicians order dated 9/24/16 for aspirin 81 mg 1 tablet by mouth one time a day, a physicians order dated 10/2/16 for diflucan 100 mg 1 tablet by mouth two time a day and a physicians ordered dated 9/30/16 for zinc sulfate 220 mg 1 tablet by mouth one time a day. An interview with Nurse #1 at 10:10 AM on 12/7/16 revealed that she was not aware that Resident #2 had orders to administer medications by mouth and indicated that it was her practice to mix medications to administer by gastrostomy tube. She indicated she administers liquid medications separately but not tablets. During an interview with the director of nurses on 12/9/16 at 11:15 AM indicated that she expects the nurses to follow physician ' s orders to administer medications as ordered, by the correct route and administer medications separately with water flushes between medications for residents with gastrostomy tubes. 2. Resident #78 was admitted on 8/22/16 with diagnoses that included intra cranial injury, and chronic respiratory failure. Review of the admission Minimum Data Set (MDS) assessment dated 9/6/16 revealed Resident #78 was rarely or never understood with severely impaired decision making. It also revealed the resident was tube fed, had a tracheostomy and used oxygen. Review of the resident ' s care plan revised on 11/1/16 revealed a plan of care for " requires tube feeding related to swallowing problem and tbi (traumatic brain injury) " that included the following intervention " the resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding	F 281	residents receiving enteral feeding to validate physicians orders are in place for flushes and tube feeding administration rates. This audit was completed by 1/6/17. 3. Licensed nurses were re-educated by the Staff Development Coordinator on the facility's policy for medication management to include the 5 Rights prior to medication administration with a focus on reading and following the physicians order, administering medications via the prescribed route, flushes as needed for gastrostomy tubes and ensuring continuous enteral feedings are administered at the physicians ordered rate. This information was included in the medication administration class that all licensed nurses attended. The DON, ADON, Unit Manager or SDC will randomly observe 5 nurses completing a medication pass weekly for 12 weeks to ensure adherence to the 5 RIGTHS prior to medication administration, administration according to the physicians order and flushes with gastrostomy tubes. Random audits will be done ongoing. The DON, ADON or Unit Manager will monitor residents with enteral feedings 3 times a week for 12 weeks to validate administration rate according to the physicians orders. Opportunities will be corrected by the nurse managers as identified during these audits. 4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and	

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F 281	Continued From page 9 orders. " Review of the Order Summary for December 2016 revealed orders dated 8/23/16 for Jevity 1.5 at 65 ml/hr (milliliters per hour) and for 160 ml water bolus (an amount given all at one time) every 4 hours. On 12/8/16 at 8:54 AM the tube feeding was observed to be running by mechanical pump at a rate of 45 ml/hr per gastrostomy tube. Inspection of the pump settings revealed that the pump was set to provide a water flush bolus of 100 ml every 2 hours. The bag of formula hung and running through the pump was inspected and revealed the following hand written on the bag " Jevity 1.5 at 45/hr, 12/8/16, 8:25 AM. " Review of the Enteral (having to do with feeding) Orders MAR/TAR reveald that Nurse # 3's initials, and a check mark indicating "administered", were present on the Enteral Orders - MAR/TAR for 12/8/16. The items signed off by Nurse #3 as administered included: Jevity 1.5 at 65 ml/hr at 7:00 AM and every 4 hours 160 ml water bolus at 8:00 AM. On 12/8/16 at 9:05 AM Nurse #3 was interviewed. She acknowledged that she had hung a new bag of Jevity 1.5 tube feeding formula for Resident #78 at 8:25 AM that morning. She was asked what rate Resident #78's tube feeding was supposed to run at. Without looking up the order she stated 45 ml/hr. Nurse #3 added that she knew it was 45 ml/hr because she had been running it at that rate since she started working with Resident #78. Nurse #3 was asked to look up the order and upon doing so she stated that the tube feeding order said Jevity 1.5 at 65 ml/hr.	F 281	then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.	

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F 281	Continued From page 10 She was also asked to see what the order for the water flush was and revealed it said 160 ml every 4 hours. Nurse #3 was informed the setting for the water flushes had been observed as 100 ml every two hours and she acknowledge the water flushes were running at the observed rate, not the rate she had just read in the orders. Nurse #3 did not indicate she noticed a discrepancy when she signed of the Enteral Orders MAR/TAR. She said that she thought there must have been an order for 45 ml/hr tube feeding and 100 ml water flushes every 2 hours that she could not find at that moment and she would research it. On 12/8/16 at 10:48 AM the Director of Nursing was interviewed. She stated that she had investigated and discovered that the tube feeding for Resident #78 had been running at the incorrect rate. The DON indicated that she expected Nursing staff to read the orders as documented in the MAR/TAR to verify the correct flow rate for tube feedings prior to administration. She also indicated that she had not yet been informed that the water flush for Resident #78 had also been running at the incorrect rate. She added that she expected nursing staff to ensure water flushes were administered as prescribed.	F 281		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and	F 322		1/6/17

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F 322	Continued From page 11 (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews a facility nurse crushed and mixed together medications, then administered them via gastrostomy tube without flushes in between the medications for 1 of 1 resident observed with a gastrostomy tube. (Resident #2) Findings included: Resident #2 was admitted to the facility on 7/27/16 with diagnosis of acute respiratory failure, quadriplegia and dysphagia. The Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 10/27/16 revealed that Resident #2 was cognitively intact and required extensive assistance with activity of daily living (ADL ' s). A medication administration observation was conducted for Resident #2 at 9:58 AM on 12/7/16. Nurse #1 was observed to crush, mix together and administer the following medications by the gastrostomy tube: baclofen, a muscle relaxant, 10 milligrams (mg) ½ tablet, aspirin, a pain reliever, 81 mg chewable 1 tablet, diflucan, an antifungal, 100 mg 1 tablet and zinc sulfate, a	F 322	1. A medication variance report was completed by the ADON on 12/8/16 for resident #78 regarding medication administration and flushes between medications. Nurse #3 received one on one education by the DON on 12/8/16 regarding the medication administration process including the 5 Rights prior to medication administration with a focus on reading and following the physicians order and proper procedure for administering crushed medications via gastrostomy tube and correct water flushes between each medication. 2. Residents with gastrostomy tubes have the potential to be affected by this alleged deficient practice. On 12/8/16 the DON and ADON observed current residents receiving medications via gastrostomy tube to validate medications were administered correctly followed by correct water flush. The DON and ADON	

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F 322	Continued From page 12 supplement, 220 mg 1 tablet. Nurse #1 mixed the crushed medications together with 30 milliliters (ml) of water, checked the gastrostomy tube for placement by pushing air into gastrostomy tube and listened for placement. Nurse #1 poured the medications mixed with water in a 60 ml syringe and administered the medications by gravity. Review of Resident #2 ' s medical record revealed a physicians order dated 9/30/16 for baclofen 10 mg ½ tablet by mouth three times a day, a physicians order dated 9/24/16 for aspirin 81 mg 1 tablet by mouth one time a day, a physicians order dated 10/2/16 for diflucan 100 mg 1 tablet by mouth two time a day and a physicians ordered dated 9/30/16 for zinc sulfate 220 mg 1 tablet by mouth one time a day. An interview with Nurse #1 at 10:10 AM on 12/7/16 revealed that she was not aware that Resident #2 had orders to administer medications by mouth and indicated that it was her practice to mix medications to administer by gastrostomy tube. She indicated she administers liquid medications separately but not the tablets. During an interview with the director of nurses on 12/9/16 at 11:15 AM indicated that she expects the nurses to follow physician ' s orders to administer medications as ordered, by the correct route and administer medications separately with water flushes between medications for residents with gastrostomy tubes.	F 322	conducted an audit or current residents receiving enteral feeding to validate physicians orders are in place for flushes with medication administration. This audit was completed by 1/6/17. 3. Licensed nurses were re-educated by the SDC on the facility's policy for medication management to include the 5 Rights prior to medication administration with a focus on reading and following the physicians order, administering medications via the prescribed route, flushes as needed for gastrostomy tubes and ensuring continuous enteral feedings are administered at the physicians ordered rate. The DON, ADON Unit Manager or SDC will randomly observe 5 nurses (3 on day shift, 1 on night shift and 1 on the weekend) completing a medication pass weekly for 12 weeks to ensure adherence to the 5 Rights prior to medication administration, administration according to the physicians order and flushes with gastrostomy tubes. Random audits will be done ongoing. The DON, ADON or Unit Manager will monitor residents with enteral feedings 3 times a week for 12 weeks to validate administration of medications according to the physicians orders. Opportunities will be corrected by the nurse managers as identified during these audits. 4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will	

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F 322	Continued From page 13	F 322	evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews and record review the facility failed to provide tube feeding and water flushes via gastrostomy tube at the prescribed rate for 1 of 3 residents that required tube feeding (Resident #78), failed to restart a tube feeding mechanical pump, after it was turned off instead of put on hold, for 1 of 3 residents that required continuous tube feeding (Resident # 78); and failed to maintain cool aerosol humidification for 1 of 1 sampled residents with a tracheostomy (Resident #78). The findings included: 1.a. Resident #78 was admitted on 8/22/16 with diagnoses that included intra cranial injury, and chronic respiratory failure. Review of the admission Minimum Data Set	F 328	1. A medication variance report was completed by the ADON on 12/8/16 for resident #78 regarding tube feeding rate and water flushes. The enteral feeding rate was verified and corrected by the DON on 12/8/16 and the feeding pump was restarted for resident #78 by Nurse #3 at the corrected administration rate. Nurse #3 received one on one education by the DON on 12/8/16 regarding the medication administration process including the 5 Rights prior to medication administration with a focus on reading and following the physicians order and verifying correct enteral feeding rates when administering continuous tube feedings.	1/6/17

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Continued From page 14

(MDS) assessment dated 9/6/16 revealed Resident #78 was rarely or never understood with severely impaired decision making. It also revealed the resident was tube fed, had a tracheostomy and used oxygen.

Review of the resident ' s care plan revised on 11/1/16 revealed a plan of care for " requires tube feeding related to swallowing problem and tbi (traumatic brain injury) " that included the following intervention " the resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders. "

Review of the Order Summary for December 2016 revealed orders dated 8/23/16 for Jevity 1.5 at 65 ml/hr (milliliters per hour) and for 160 ml water bolus (an amount given all at one time) every 4 hours.

Review of the resident's weight history revealed no weight loss with an admission weight of 164 pounds and a weight on 12/5/16 of 165 pounds.

On 12/7/16 at 1:15 PM the tube feed was observed to be running by mechanical pump at a rate of 45 ml/hr. per gastrostomy feeding tube (G-tube). Inspection of the pump settings revealed that the pump was set to provide a water flushes of 100 ml every 2 hours.

On 12/7/16 at 3:55 PM the tube feed was observed to be running by mechanical pump at a rate of 45 ml/h. per G-tube. Inspection of the pump settings revealed that the pump was set to provide a water flush bolus of 100 ml every 2 hours.

F 328

The Aerosol humidifier was replaced by the charge nurse for resident #78 on 12/8/16. Nurse #3 was educated to monitor humidification bottle water level on trach residents when in the room and change bottles when necessary.

2. Current residents have the potential to be affected by this alleged deficient practice. On 12/8/16 the DON and ADON observed current residents receiving continuous enteral feeding to validate feedings were administered at the physicians ordered rate. The DON and ADON conducted an audit of current residents receiving enteral feeding to validate physicians orders are in place for flushes and tube feeding administration rates. This audit was completed by 1/6/17.

On 12/8/16 the DON observed current residents with tracheostomies to ensure aerosol humidifiers were in place with adequate water supply.

3. Licensed nurses were re-educated by the SDC on the facility policy for medication management to include the 5 Rights prior to medication administration with a focus on reading and following the physicians order, administering medications via the prescribed route, ensuring continuous enteral feedings are administered at the physicians ordered rate and restarting the pump after placing on hold. Nurses also educated on the reason why to place on hold rather than stop when providing care. Pump will lalarm in left on hold where as no alarm

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F 328	Continued From page 15 On 12/7/16 at 5:00 PM the tube feed was observed to be running by mechanical pump at a rate of 45 ml/hr per G-tube. Inspection of the pump settings revealed that the pump was set to provide a water flush bolus of 100 ml every 2 hours. On 12/8/16 at 8:54 AM the tube feeding was observed to be running by mechanical pump at a rate of 45 ml/hr per G-tube. Inspection of the pump settings revealed that the pump was set to provide a water flush bolus of 100 ml every 2 hours. The bag of formula hung and running through the pump was inspected and revealed the following hand written on the bag " Jevity 1.5 at 45/hr, 12/8/16, 8:25 AM. " On 12/8/16 at 9:05 AM Nurse #3 was interviewed. She acknowledged that she had hung a new bag of tube feeding formula (Jevity 1.5) for Resident #78 at 8:25 AM that morning. She was asked what rate Resident #78 ' s tube feeding was supposed to run at. Without looking up the order she stated 45 ml/hr. Nurse #3 added that she knew it was 45 ml/hr because she had been running it at that rate since she started working with Resident #78. Nurse #3 was asked to look up the order and upon doing so she stated that the tube feeding order said Jevity 1.5 at 65 ml/hr. She was also asked to see what the order for the water flush was and revealed it said 160 ml every 4 hours. Nurse #3 was informed the setting for the water flushes had been observed as 100 ml every two hours and she acknowledge the water flushes were running at the observed rate, not the rate she had just read in the orders. Nurse #3 said she thought there was an order for 45 ml/hr tube feeding and 100 ml water flushes every 2 hours that she could not find at that moment and	F 328	will be given if left on stop. The DON, ADON or Unit Manager will randomly observe 5 nurses completing a medication pass weekly (3 on day shift, 1 on night shift and 1 on the weekend) for 12 weeks to ensure adherence to the 5 Rights prior to medication administration and accurate administration of feedings, water flushes and trach humidification according to the physicians order. Audits will be random ongoing. The DON, ADON or Unit Manager will observe residents with tracheostomies to ensure aerosol humidifiers are in place with adequate water supply. Opportunities will be corrected by the nurse managers as identified. Licensed nurses were educated on 12/8/16 to monitor humidification bottle water levels on trach residents when in the room and to change bottles when necessary, 4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate effectiveness and amend as needed. Date of compliance is 1/6/17.	

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F 328	Continued From page 16 she would research it. On 12/8/16 at 9:15 AM the Assistant Director of Nursing (ADON) was interviewed. She reviewed the Enteral Feed Orders for Resident #78 and confirmed tube feeding order was Jevity 1.5 at 65 ml/hr and the order for water flushes was 160 ml every 4 hours. She also acknowledged that running the tube feed at 45/hr and flushing with 100 ml water every 2 hours was incorrect, according to the orders. She stated she wanted to look into the matter before commenting further. On 12/8/16 at 10:48 AM the Director of Nursing was interviewed. She stated that she had investigated and discovered that the tube feeding for Resident #78 had been running at the incorrect rate. She indicated she did not have an explanation for why but added that Nurse #3 had been working with Resident #78 at times for the past 2 weeks and had been in another position prior to that. The DON added that they had corrected the rate and had reviewed Resident #78 ' s weights and found no weight loss. She acknowledged that there were 2 other residents in the facility with tube feedings that were ordered to run at 45 ml/hr but the rate for Resident #78 was supposed to be 65 ml/hr. The DON indicated that she expected Nursing staff to read the orders as documented in the MAR/TAR to verify the correct flow rate for tube feedings prior to administration. She also indicated that she had not yet been informed that the water flush for Resident #78 had also been running at the incorrect rate. She added that she expected nursing staff to ensure water flushes were administered as prescribed. 1.b. Resident #78 was admitted on 8/22/16 with	F 328		

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diagnoses that included intra cranial injury, and chronic respiratory failure.

Review of the admission Minimum Data Set (MDS) assessment dated 9/6/16 revealed Resident #78 was rarely or never understood with severely impaired decision making. It also revealed the resident was tube fed, had a tracheostomy and used oxygen.

Review of the resident's care plan revised on 11/1/16 revealed a plan of care for requires tube feeding related to swallowing problem than included the following intervention " the resident is dependent with tube feeding and water flushes. See MD (Medical Doctor) orders for current feeding orders. "

Review of the Order Summary for December 2016 revealed an orders dated 8/23/16 for Jevity 1.5 at 65 ml/hr (milliliters per hour).

On 12/7/16 at 3:55 PM Nurse #4 was observed providing resident #78 wound care. Prior to initiating wound care Nurse #4 put the resident's tube feed on hold. During wound care the mechanical pump for the tube feed started to feed and she turned the tube feed off. At 4:30 PM wound care was completed and Nurse #4 exited the room without turning the tube feedback on.

On 12/7/16 at 5:00 PM Nurse #4 and the Assistant Director of Nursing (ADON) entered Resident #78 ' s room to reinforce the resident's wound VAC (Vacuum Assisted Closure) dressing. The ADON looked at the mechanical tube feed pump and did not make any adjustments. At 5:18 PM the treatment was completed and Nurse #4

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and the ADON exited the room without turning the tube feed on.

On 12/7/18 at 5:19 PM Nurse #4 was interviewed. She was asked if there was anything that she still needed to do for Resident #78. She stated that the resident's tube feed needed to be turned back on and added that she was going to tell the hall nurse to do it. Nurse #4 then acknowledged that she would normally turn the tube feed on herself and that she should have done that before leaving the room but forgot as she was nervous being observed.

On 12/9/16 at 1:30 PM the Director of Nursing (DON) was interviewed. She stated that the facility policy was that staff were not to turn off the mechanical tube feeding pumps and could only put them on hold. She stated that by putting the pump on hold it would beep as a reminder to turn it back on but that if it was turned off there was no beeping and no reminder. The DON said she expected staff to follow the policy and only put the pumps for tube feedings on hold when needed. She added that the tube feed for Resident #78 should not have been left off after his treatment was completed.

1.c. Resident #78 was admitted on 8/22/16 with diagnoses that included intra cranial injury, and chronic respiratory failure.

Review of the admission Minimum Data Set (MDS) assessment dated 9/6/16 revealed Resident #78 was rarely or never understood with severely impaired decision making. It also revealed the resident was tube fed, had a tracheostomy and used oxygen.

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F 328	Continued From page 19 Review of the resident's care plan revised on 11/1/16 revealed a plan of care for tracheostomy related to traumatic brain injury. Interventions included oxygen as ordered, observe secretions and, trach (tracheostomy) care as ordered." Review of the Order Summary for December 2016 revealed an order dated 8/25/16 for " cool air aerosol trach mask at 28% (percent) FIO2 (Fraction of Inspired Oxygen) related to tracheostomy status continuous." On 12/7/16 at 1:15 PM the sterile water bottle providing cool air aerosol humidification via mask to Resident #78's tracheostomy site was observed to be empty. A family member was present in the room at this time and interviewed. She stated that she had noticed that the water for humidification of the tracheostomy was empty a little earlier when the nurse was in the room and thought she had mentioned it to her. On 12/7/16 at 3:55 PM the sterile water bottle providing cool air aerosol humidification via mask to Resident #78 ' s tracheostomy site was observed to be empty. On 12/7/16 at 5:00 PM the sterile water bottle providing cool air aerosol humidification via mask to Resident #78's tracheostomy site was observed to be empty. On 12/7/16 at 5:22 PM Nurse #1 was interviewed. She stated that she had last been in the room around lunchtime and she thought there had been about 1 inch of water left in the cool aerosol bottle for humidification of Resident # 78's tracheostomy. She added that she needed to go and attach a new bottle of sterile water right away	F 328		

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F 328	Continued From page 20 if the current one providing humidification to the resident's tracheostomy airway site was empty. She added that the resident should not have been without the humidification to his tracheostomy airway as without if his airway would get too dry. On 12/8/16 at 8:54 AM the sterile water bottle providing cool air aerosol humidification via mask to Resident #78's tracheostomy site was observed to be empty. A family member was in the room and stated she had been there since the evening before. She recalled a nurse replacing the sterile water with a new bottle around 5:30 PM the evening before but she wasn't sure if anyone had been in to change it or checked on it when they were in during the night. On 12/8/16 at 10:58 AM the Director of Nursing (DON) was interviewed. She stated that she was not aware that Resident #78's cool aerosol humidification, for his tracheostomy airway, had been empty for several hours on 12/7/16 and again on the morning of 12/8/16. She indicated that she expected staff to check the humidification water every time they went in the room to provide care. She further indicated that she expected the humidification water for the resident ' s tracheostomy would never be empty. The DON said the concern with it being empty was that the resident's airway could get dry. She also acknowledged that it could cause his secretions to be thicker.	F 328		
F 332 SS=E	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.	F 332		1/6/17

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F 332	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews the facility ' s medication error rate was greater than 5% as evidence by 6 medication errors out of 28 opportunities, resulting in a medication error rate of 21.4% for 2 of 6 residents observed during medication administration (Resident #2 and #44). Four medicines were administered via wrong route and two medications were omitted. Findings included: 1. Resident #2 was admitted to the facility on 7/27/16 with diagnosis of acute respiratory failure, quadriplegia and dysphagia. The Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 10/27/16 revealed that Resident #2 was cognitively intact and required extensive assistance with activity of daily living (ADLs). A medication administration observation was conducted for Resident #2 at 9:58 AM on 12/7/16. Nurse #1 was observed to crush, mix and administer by gastric tube the medications baclofen, a muscle relaxant, 10 milligrams (mg) ½ tablet, aspirin, a pain reliever, 81 mg chewable 1 tablet, diflucan, an antifungal, 100 mg 1 tablet and zinc sulfate, a supplement, 220 mg 1 tablet. Review of Resident #2 ' s medical record revealed a physicians order dated 9/30/16 for baclofen 10 mg ½ tablet by mouth three times a day, a physicians order dated 9/24/16 for aspirin 81 mg 1 tablet by mouth one time a day, a physicians order dated 10/2/16 for diflucan 100 mg 1 tablet by mouth two time a day and a physicians ordered dated 9/30/16 for zinc sulfate 220 mg 1 tablet by mouth one time a day.	F 332	1. 2 medication variance report were completed by the ADON on 12/7/16 for resident #2 and resident #44. On 12/7/16 the ADON contacted the physician and reviewed resident #2's medication orders and a new order was received to change the route to via gastrostomy tube and for flushes with medication administration. Nurse #1 received one on one education by the DON on 12/7/16 regarding the medication administration process including the 5 Rights prior to medication administration with a focus on reading and following the physicians order and administering medications via the prescribed route and administration of medications for residents with gastrostomy tubes. 2. Current residents have the potential to be affected by this deficient practice. Physician notified of the medications that were omitted and the medications were given at the next scheduled time. Licensed nurses were educated to inform the MD of any medications omitted, the reason for omission and for follow up orders. 3. Licensed nurses were re-educated by the SDC on the facility policy for medication management to include the 5 Rights prior to medication administration with a focus on reading and following the physicians order, administering	

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F 332	Continued From page 22 Further record review for Resident #2 revealed a physicians order dated 9/30/16 for restasis emulsion, for dry eyes, instill 1 drop in both eyes every 12 hours, which was observed to be omitted and not given as ordered. 2. Resident #44 was admitted to the facility on 11/18/16 with the diagnosis of myocardial infarction and chronic obstructive pulmonary disease. The admitting MDS assessment with the ARD of 11/25/16 revealed that Resident #44 was cognitively intact and required extensive assistance with ADLs. Review of Resident #44 ' s medical record revealed a physicians order dated 11/18/16 for tiotropium bromide monohydrate, a bronchodilator, 18 micrograms 1 capsule inhale orally one time a day. A medication administration observation was conducted for Resident #44 on 12/7/16 at 9:40 AM. Nurse #1 was observed to omit the medication tiotropium bromide monohydrate inhaler. During an interview with the director of nurses on 12/9/16 at 11:15 AM indicated that she expects the nurses to follow physician ' s orders to administer medications as ordered and by the correct route.	F 332	medications via the prescribed route, flushes as neede for gastrostomy tubes and ensuring continuous enteral feedings are administered at the physicians ordered rate. The DON, ADON, Unit Manager or SDC will randomly observe 5 nurses (3 on day shift, 1 on night shift and 1 on the weekend) completing a medication pass weekly for 12 weeks to ensure adherence to the 5 Rights prior to medication administration, administration according to the physicians order and flushes with gastrostomy tubes. Random audits will be done ongoing. Opportunities will be corrected by the nurse managers as identified during these audits. 4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		1/6/17

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F 371	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean 4 of 4 air conditioning unit (AC) vents in the ceiling over food preparation and serving areas and failed to clean 2 of 2 fire extinguishers. Two of four dietary staff (Dietary staff #1 and Dietary staff #2) failed to ensure that their hair restraint covered all of their hair in two of two kitchen observations. Dietary manager failed to ensure that his beard restraint covered all of his beard in two of two kitchen observations. Findings included: 1. An initial tour of the kitchen was conducted on 12/5/16 at 10:45 AM. A grey, powdery substance was noted on the four AC vents in the main kitchen, two were located directly over the food serving area and food preparation area. A dark brown sticky substance was noted on both of the fire extinguishers during the initial tour on 12/5/16 at 10:45 AM, one extinguisher located beside the hand washing sink and the other by the dietary manager ' s office. The kitchen was observed again on 12/5/16 at 3:25 PM. The grey, powdery substance remained on all the AC vents and the brown, sticky substance remained on both of the fire extinguishers. The kitchen was observed on 12/5/16 at 5:10 PM and one of the four AC vents directly over the serving area was noted to be cleaned and no powdery substance was noted on the surface of the vent. The Administrator climbed up on a step ladder and wiped off an AC vent far away from the serving area. The grey powdery substance	F 371	1. Dietary employees are now using hair restraints including beard restraints to cover head and facial hair by 1/6/17. Four air conditioning vents were cleaned and painted and two fire extinguishers were cleaned by the Dietary Manager and Maintenance Supervisor on 12/8/16. 2. Current residents have the potential to be affected by this alleged deficient practice. 3. Current dietary Department staff were re-educated by the Dietary Manager regarding proper hair restraint to cover head and facial hair by using hair nets and beard guards by 1/6/17. Hair restraints are to be validated for use 5 times a week for 12 weeks by the Administrator or Nurse Manager. Cleaning of vents will remain on a weekly cleaning checklist and cleaning of the vents will be executed by the dietary department staff or manager every week. Wall hanging items, such as fire extinguishers, have been added to the dietary department weekly cleaning checklist and cleaning of wall hanging items will be executed by the dietary department staff or manager. The fire extinguishers were cleaned prior to being put on the checklist when the deficiency was addressed by the dietary manager.	

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F 371	Continued From page 24 came off the vent onto the white cloth. The brown sticky substance was noted to remain on both of the fire extinguishers on 12/5/16 at 5:10 PM. The Dietary Manager was interviewed on 12/5/16 at 3:25 PM. He reported he usually cleaned the AC vents once a week, but was unable to provide a cleaning record. An interview was conducted with the Administrator on 12/5/16 at 5:10 PM. He stated he felt the discolorations were due to heat and the AC vents needed to be repainted. An interview was conducted with the Dietary Manager on 12/7/16 at 3:41 PM the brown, sticky substance was noted to remain on both fire extinguishers. The Dietary Manager stated he would have both cleaned. 2. An initial tour of the kitchen was conducted on 12/5/16 at 10:45 AM. The Dietary Manager was noted to wear a beard guard that did not cover all his facial hair, exposing parts of his upper lip and left side of his face. The kitchen was observed on 12/5/16 at 3:25 PM and the dietary manager was noted to have the beard guard on, but the left half of his facial hair was exposed. The kitchen was observed on 12/5/16 at 5:10 PM during the serving of the evening meal. Dietary Staff #1 had a hair net on, but her bangs were not covered. The kitchen was observed on 12/7/15 at 3:41 PM and Dietary Staff #2 had a hair net on, but her bangs were not covered. An interview was conducted with the Dietary Manager on 12/7/16 at 3:41 PM and he stated the dietary staff did not like to cover all of their hair, they thought it was unattractive. He stated the beard guard was difficult to keep over his facial hair due to facial movement. He stated he would	F 371	Current dietary staff were re-educated by the dietary manager regarding the kitchen cleaning schedule to include weekly cleaning of the air conditioning cents and fire extinguishers. The Dietary Manager and the Administrator will audit the cleaning schedule weekly for 12 weeks to validate completion of scheduled cleaning tasks to include air conditioning vents and fire extinguishers.. 4. The Dietary Manager will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate effectiveness and amend as needed. Date of compliance is 1/6/17.	

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F 371	Continued From page 25 enforce the correct use of hairnets for all dietary employees.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. 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.	F 431		1/6/17

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F 431	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations during medication administration, the facility failed to secure 2 of 3 medication carts (100 hall medication cart and 300 hall medication cart) observed during medication administration. Findings included: On 12/7/16 at 9:20 AM the 100 hall medication cart was noted to be unattended and unlocked across the hall from room 104 where nurse #1 was completing a task with the door shut. During the observation there were no staff present. The medication cart remained unattended and unlocked until nurse #1 completed the task in room 104 at 9:35 AM. Nurse #1 returned to the 100 hall medication cart, locked the cart and went to the 300 hall. A second observation on 12/7/16 at 9:40 AM during medication administration observation on 300 hall, nurse #1 failed to check that the medication cart was secured. The 300 hall medication cart was observed unlocked and unattended while nurse #1 was in rooms 305, 306 and 314 on the 300 hall from 9:40 AM to 10:53 AM on 12/7/16. An interview with nurse #1 on 12/7/16 at 10:54 AM revealed that she was not aware that the medication carts on 100 and 300 halls were left unlocked during medication administration. She thought she pushed the latch in all the way and secured the carts. During an interview with the director of nurses on 12/7/16 at 10:55 AM indicated that her expectations were that anytime a nurse walks away from the medication cart and not in eyesight, the medication cart should be locked.	F 431	1. The medication cart was immediately secured on 12/7/16 by the DON and the Maintenance Supervisor. Nurse #1 was re-educated on 12/7/16 on steps to push the lock on the medication cart and securing the medication cart prior to stepping away. 2. Current residents have the potential to be affected by this alleged deficient practice. The SDC re-educated licensed nurses regarding the facility policy and procedure for locking the medication cart prior to stepping away, including pushing the lock all the way in and checking the drawer to ensure that it is locked by 1/6/17. 3. The DON, ADON and nurse managers will audit all medication carts weekly for 12 weeks to verify medication carts are secure and locked when unsupervised. Opportunities will be corrected as identified. 4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate effectiveness and amend as needed. Date of compliance is 1/6/17.	

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F 441	Continued From page 27	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		1/6/17

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: The facility failed to have an isolation precautions sign posted at the entrance to the room for 1 of 1 residents with an order for isolation precautions (Resident # 21). The findings included: Review of the Admission Minimum Data Set (MDS) revealed Resident #21 was cognitively impaired, did not have a catheter and was frequently incontinent of urine. Review of the physician orders for Resident #21 revealed an 11/18/16 order for a urine culture and sensitivity. The 11/22/16 results indicated presence of Extended-spectrum beta-lactamase (ESBL) and Klebsiella pneumoniae. Review of the Physician Orders revealed an order for contact isolation and an antibiotic was also ordered to be taken for 7 days. On 12/5/16 at 10:48 AM room 308 was observed to have set of plastic drawers containing personal protective equipment beside the doorway. There was no isolation precautions sign posted on or near the door or equipment. On 12/5/16 at 3:00 PM Nurse #5 was interviewed. She indicated that she could not recall what type of isolation Resident #21 was on but stated that she thought it was for a urinary tract infection. Nurse #5 also stated she could not recall if there had ever been an isolation sign on the door. On 12/5/17 at 3:09 PM room 308 was observed to have set of plastic drawers containing personal protective equipment beside the doorway. There was no isolation precautions sign posted on or near the door or equipment. On 12/6/16 at 1:18 PM room 308 was observed to have set of plastic drawers containing personal	F 441	1. Resident #21 in contact isolation for urinary tract infection with ESBL. Contact isolation sign placed on door by the DON on 12/8/16. 2. Current residents in isolation have the potential to be affected by this alleged deficient practice. An audit of current residents in isolation was conducted by the DON, ADON and Unit Manager to ensure accurate signage was posted outside each resident room door by 1/6/17. Infection control nurse or designee will initiate placement of isolation sign and equipment. 3. Licensed nurses were re-educated by the SDC regarding the use and placement of signage indicating a resident is on isolation protocols. This education was completed by 1/6/17. All nurses have been educated on location of isolation carts and signs by the infectoin control nurse, completed 12/23/16. Other staff were educated by the infection control nurse to notify charge nurse if an isolation sign is missing from a room, completed 1/6/17. The DON, ADON or Unit Manager will monitor residents in isolation weekly for 12 weeks to ensure proper signage to indicate isolation is posted outside each resident room door. Audits will be random ongoing. Opportunities will be corrected as identified by the nurse managers.	

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F 441	Continued From page 29 protective equipment beside the doorway. There was no isolation precautions sign posted on or near the door or equipment. On 12/7/16 at 9:42 AM a contact isolation precaution sign was observed on the door of room 308 A set of plastic drawers containing personal protective equipment also present beside the doorway. On 12/9/16 at 1:30 PM the Assistant Director of Nursing/Infection Control Practitioner (ADON) was interviewed with the Director of Nursing (DON) and Administrator present. She stated that Resident #21 was still on contact precautions for urinary tract infection with ESBL and that the Centers for Disease Control recommendation was for contact precautions to be discontinued after two negative urine samples, which should not be taken until 4 days after the completion of antibiotics. The ADON stated that she recalled putting the contact isolation precaution sign on the resident ' s door when isolation was started on 11/22/16 and said that she believed the sign had been present every day since then. She did not know why the required contact isolation precaution would have been observed missing for almost 24 hours during the survey.	F 441	4. The DON will report the results of these audits and monitoring to the QAPI committee for 3 months, quarterly and then as needed. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 1/6/17.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		1/6/17

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committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and to monitor the interventions the committee put into place following the 1/7/16 recertification survey. This was for one deficiency which was recited during the facility ' s 12/9/16 recertification survey in the area Services Provided Meet Professional Standards (F281). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included:

This tag is cross referenced to:

F281 Services Provided Meet Professional Standards: Based on observation, record reviews and staff interviews: (1) a facility nurse failed to

F 520

Criteria #1
Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 12/29/16 to discuss the outcomes of the annual survey and repeat citations of F281 providing services to meet professional standards.

QAPI education was provided for the Administrator, Director of Nursing and the interdisciplinary team by the Divisional Director of Clinical Services on 1/6/17. This education included the facility policy, procedure and expectations for QAPI. The program enables the identification of opportunities for improvement, prioritization of those opportunities, root cause analysis, performance improvement plans and evaluation of the

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F 520	Continued From page 31 follow the professional standard to administer medications orally as ordered, and instead crushed the medications, mixed them together, and administered them without water flushes via gastrostomy tube for 1 of 1 resident observed during medication administration (Resident #2). Also, (2) a facility nurse failed follow professional standards by not reading physician's orders as documented on the MAR/TAR (Medication Administration Record/Treatment Administration Record) to verify the prescribed rate when administering a continuous tube feeding and bolus water flushes for 1 of 3 residents that had a gastrostomy tube (Resident #78). During the 1/7/16 recertification survey the facility had a F281 citation for failing to follow physician ' s orders for medication administration. On 12/9/16 at 1:30 PM the Director of Nursing (DON) was interviewed with the Administrator and Assistant Director of Nursing (ADON) present. The DON indicated that they had worked on the F281 from the previous recertification survey but that it had to do with transcribing orders. She said that the current F281 deficiency was different in that it had to do with not checking already transcribed orders prior to carrying them out. She also noted that the facility had recently changed over to an electronic medical record within the past few months that could have been a contributing factor. The DON indicated that she expected staff to accurately transcribe orders and to carry out orders as they were written.	F 520	PIP through plan, do, study, act philosophy to ensure sustainability. Criteria #2 Current residents have the potential to be affected by this alleged deficient practice. On 12/8/16 the DON and ADON observed current residents receiving continuous enteral feeding to validate feedings were administered at the physicians ordered rate. The DON and ADON conducted an audit of current residents receiving enteral feeding to validate physicians orders are in place for flushes and tube feeding administration rates. This audit was completed by 1/6/17. Criteria #3 Interdisciplinary Department Head Team were re-educated by the Director of Nursing and the Administrator regarding the regulatory requirement for F281 providing services to maintain professional standards. This education was completed by 1/6/17. The Administrator will hold a weekly Ad Hoc QAPI committee meeting for 12 weeks to review F281 providing services to maintain professional standards to ensure all regulatory aspects are addressed and in compliance. Opportunities will be corrected as identified. Criteria #4 The Administrator and Director of Nursing will analyze the data obtained and report any patterns and/or trends to the QAPI committee monthly for 12 months. The QAPI committee will evaluate the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING ______ B. WING ______	C 12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/MONROE	**204 OLD HIGHWAY 74 EAST** **MONROE, NC 28112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 32	F 520	effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance.	