STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and nurse practitioner interviews and record review, the facility failed to obtain a urine specimen, begin antibiotic therapy and assess 1 of 3 sampled residents with significant condition changes (Resident #1). The findings included: Resident #1 was admitted to the facility on 07/10/09 with diagnoses which included Alzheimer's Disease. Review of Resident #1's quarterly Minimum Data Set (MDS) dated 01/14/14 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #1 was always incontinent of urine. Review of a nurse practitioner (NP) note dated 02/17/14 revealed nursing staff requested a visit due to an elevated temperature of 101.4 degrees Fahrenheit (F.) on 02/16/14 at 5:00 PM which decreased to 99.2 degrees after Tylenol (used to lower fever) adminstration. The NP documented an assessment of "lethargy, fatigue, chronic confusion and tachycardia at times bounding."	F 309	F309 Address how corrective action will be accomplished for each resident found to be affected by the deficient practice: Resident #1 was discharged to the hospital and did not return to the facility. Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents with a change in condition are at risk related to this alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	3/4/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/18/2014

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 309	Continued From page 1 The NP documented Resident #1 was bedfast and if fluids were unable to be taken by mouth, intravenous fluids would be discussed with Resident #1's family members. Review of NP's orders dated 02/17/14 revealed direction to obtain an urinalysis with culture and sensitivity and begin Rocephin (an antibiotic) 1 Gram intramuscular injection daily which could be given with lidocaine (a topical anesthetic). A chest x-ray due to fever and encouragement of fluids were also ordered. This order was signed as received by Nurse #3. Review of Resident #1's February 2014 Medication Administration Record revealed transcription of the Rocephin order with the direction to begin after the urinalysis was obtained. There was no documentation of Rocephin administration. Review of Resident #1's nursing notes dated 02/17/14 and 02/18/14 revealed there was no documentation of an assessment. There was no documentation of attempts to obtain a urine specimen. Review of Resident #1's situation, background assessment, request communication (SBAR) form dated 02/18/14 at 10:00 AM, completed by Nurse #1, revealed documentation of a heart rate of 108 and a temperature of 101.4 degrees F. The documentation described Resident #1 with facial drooping and symptoms of a transient ischemic attack (TIA). Review of the NP's telephone order dated 02/18/14 revealed direction to transfer Resident #1 to the emergency room for evaluation of	F 309	Licensed Nursing staff will be re-educated by the Staff Development Coordinator or designee on identifying and monitoring a change in condition of a resident. Residents with a change in condition will be discussed at morning clinical leadership meeting on weekdays. The Unit Manager or designee will review the charts of residents noted on the 24h report with a significant change in condition, new laboratory orders, or from the Stop and Watch tools to ensure ongoing assessments and monitoring related to any change in condition. The Unit Manger or Designee will report any findings or follow-up on a copy of the 24h report given to the DON (Director of Nursing) or designee with follow-up 5x per week for 2 weeks, 3x per week for 2 weeks, then monthly x2 months. Opportunities will be corrected as identified during monitoring with immediate staff education as indicated. Any nurse not documenting monitoring will be disciplined using the progressive discipline process. Indicate how the facility plans to monitor the measures to make sure that solutions are sustained: The monitoring reviews will be analyzed by the Director of Nursing (DON) for patterns and trends and presented to the QA&A committee monthly. The QA&A committee will recommend further education or systemic changes as needed.	

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F 309	Continued From page 2 elevated temperature and possible TIA. Review of Resident #1's emergency room admission history and physical exam dated 02/18/14 revealed a diagnosis of sepsis due to urinary tract infection with an admission temperature of 100.1 degrees F. and a heart rate of 108. Resident #1's urinalysis result dated 02/18/14, obtained in the emergency room, listed a turbid appearance with large amounts of blood and white blood cells. Resident #1 received intravenous antibiotics in the emergency room and was admitted to the hospital for treatment of the urinary tract infection. A computed tomography (CT) scan of the head revealed there were no acute changes. Interview with Nurse #1 on 02/24/14 at 1:46 PM revealed Resident #1 was seen by the NP on 02/17/14 in response to an evening shift nurse request regarding an elevated temperature on 02/16/14. Nurse #1 reported Resident #1 began to sweat profusely with a facial droop the morning of 02/18/14. Nurse #1 reported she contacted the NP and transferred Resident #1 to the emergency room. Nurse #1 explained Resident #1 did not begin the Rocephin injections since a urine specimen had not been obtained. Nurse #1 explained Resident #1 would require a straight catherization to obtain a urine specimen. Nurse #1 reported she did not know the reason the urine specimen was not obtained but attempts would be documented in the nursing notes. Nurse #1 explained she received no special information regarding Resident #1 in report the morning of 02/18/14. Telephone interview with Nurse #2 on 02/24/14 at 3:55 PM revealed Nurse #3 informed her of the	F 309		

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F 309	Continued From page 3 order to obtain Resident #1's urine specimen and begin antibiotic therapy. Nurse #2 explained she worked from 7:00 PM to 11:00 PM on 02/17/14. Nurse #2 reported she did not attempt to obtain the urine specimen since night shift usually obtained urine specimens. Nurse #2 reported she informed the night nurse, Nurse #4, of the need for a specimen and initiation of antibiotic therapy. Nurse #2 explained she did not remember if she assessed Resident #1 but the assessment would be documented in the nursing notes. Telephone interview with the NP on 02/24/14 at 4:13 PM revealed she did not receive notification Resident #1's urine specimen was not obtained and antibiotic therapy not initiated. The NP explained she expected staff to obtain the urine specimen upon receipt of the order and not wait until the night shift. The NP explained she would expect to be notified if the urine could not be obtained so she could direct staff to initiate the antibiotic therapy. The NP reported she expected staff to monitor Resident #1 which would include temperature measurements. Telephone interview with Nurse #3 on 02/24/14 at 4:55 PM revealed she took off the order to obtain the urine specimen at the end of her shift at 7:00 PM on 02/17/14. Nurse #3 reported she transcribed the Rocephin order and completed a laboratory requisition slip. Nurse #3 reported she informed Nurse #2 of the need to obtain the urine specimen and give the Rocephin. Nurse #3 could not recall if she assessed Resident #1 after the NP visit. Telephone interview with Nurse #4 on 02/25/14 at 7:55 AM revealed she worked from 11:00 PM on	F 309		

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F 309	Continued From page 4 02/17/14 to 7:00 AM on 02/18/14. Nurse #4 reported she was not aware of the order to obtain a urine specimen and begin antibiotic therapy for Resident #1. Nurse #4 explained she spoke to Resident #1 during the night and he did not appear ill. Interview with the Staff Development Coordinator (SDC) on 02/25/14 at 9:20 AM revealed she was the resource person in the absence of the Director of Nursing. The SDC explained the NP did not order the urine specimen as a stat (immediate) order so the night shift would be responsible for the specimen. The SDC reported the need for the specimen would be communicated orally and written on the 24 hour report. The SDC reported there was no documentation of attempts to obtain a specimen and could not provide the 24 hour report for review. The SDC reported there was no available documentation of vital sign measurements or assessments of Resident #1 from 02/17/14 until the transfer to the hospital on 02/18/14.. The SDC reported she expected staff to document attempts to obtain the urine specimen and assessments of Resident #1.	F 309		