STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING ______ B. WING ______	C 01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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=D	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 record review, resident and staff interviews, and observations, the facility failed to ensure there was a clear order for oxygen and it was being administered as ordered by the physician for 3 of 3 residents reviewed for well-being Resident #31, Resident #6, Resident #248). Findings included: 1) Resident #31 was admitted to the facility on 10/14/14. Diagnoses included: Hypertension, Renal Failure, Diabetes Mellitus, Hyperlipidemia, Atrial Fibrillation, Polyneuropathy, and Chronic Kidney Disease. A review of the most recent Minimum Data Set (MDS) dated 10/29/15, indicated the resident is alert and oriented, and had a Brief Interview for Mental Status (BIMS) of 15. She required extensive to one person physical assistance with Activities of Daily Living (ADLs) and bed mobility, and required extensive to two person physical assistance with transfers. Oxygen use was not indicated on her MDS dated 10/29/15. The current care plan indicated the resident was on oxygen therapy. A record review indicated a physician's order dated 11/29/15 read, "Oxygen at 2 L/NC prn".	F 309	Resident #6 #31's physician orders for oxygen were reviewed and clarified as needed on 1/7/16 by the Assistant Director of Nursing to validate the amount of oxygen liter flow the resident was to receive. Residents 36 and #31 were physically assessed by nurse unit managers to check the resident's oxygen saturation levels and ensure the residents were receiving oxygen at the correct liter flow ordered. Resident #248 was hospitalized during time of survey. Resident was readmitted on 1/9/16 and orders for oxygen were reviewed on day of admission. An audit of resident physician orders began on 1/7/16 and completed on 1/8/16 to identify all residents utilizing oxygen. All residents identified with oxygen orders were checked to ensure they were receiving the accurate liter flow of oxygen as ordered by the physician. Nursing staff were inserviced beginning on 1/6/16 by the Staff Development	1/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/22/2016

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.

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BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	**1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534**

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F 309	Continued From page 1 During an observation on 1/6/16 at 2:30 pm, the resident's oxygen concentrator was set at 3 Liters/minute (L/min) via nasal cannula (NC). An interview with resident #31 on 1/6/16 at 2:30 pm was conducted. She indicated that she was supposed to receive 2 L/min, not 3 L/min. An interview with nurse #1 was conducted on 1/6/16 at 2:50 pm, she indicated the resident's oxygen order was for 2 Liters of continuous oxygen per minute via nasal cannula. An observation on 1/6/16 at 3:00 pm was made with nurse #1 present. Nurse #1 verified the oxygen concentrator for resident #31 was set at 3 Liters per minute and adjusted the oxygen concentrator to 2 Liters per minute. An interview with nurse #1 was conducted on 1/6/16 at 3:50 pm. She indicated she checked the resident's oxygen concentrators on her unit every morning and the nurses assigned to the resident's should also check the resident's oxygen concentrator delivery level. She indicated there was no record of documentation to reflect this information, she stated, "I just know who to check". She indicated the resident received continuous oxygen because "she likes it on" , but verified the physician order was for "as needed ". An interview was conducted with the Director of Nursing on 1/6/16 at 4:22 pm. She indicated her expectation was for each nurse to monitor the resident's oxygen concentrator settings. 2. Resident # 6 was admitted to the facility in August 2014 and was readmitted on 9/18/14 with a diagnosis history that included essential hypertension, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and hyperlipidemia. The most recent Minimum Data Set (MDS), dated 10/30/15, indicated that resident # 6 was	F 309	Coordinator on the importance and expectation of ensuring that all residents who utilize oxygen receive oxygen as prescribed by their physician. Newly hired nursing staff will receive the education during orientation. Licensed nurses will validate every shift that residents identified with continuous oxygen orders are being administered per physician orders. The licensed nurse will document on the medication administration record that oxygen is being administered. The Director of Nursing or designee will audit a minimum of four residents identified with orders for continuous oxygen to ensure resident is receiving the correct liter flow ordered and that documentation is in compliance weekly times four and monthly times two. The results of the audit will be reported to the Quality Assurance Committee monthly times three. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 309	Continued From page 2 cognitively intact and received oxygen (O2) therapy. She was also care planned for O2 therapy. At 4:00 PM on 1/6/16 during an observation of Resident #6, along with Nurse #1, it was noted that her oxygen concentrator was set at 1.5 liters per minute (L/min). Nurse #1 stated she did not know the resident's order for oxygen because she was not the unit manager for the 200 hall station. Resident #6's orders were reviewed and showed O2 ordered at 4L/min via nasal cannula (NC). On 1/7/16 at 10:55 AM, Resident #6 was sitting up in her wheelchair with oxygen concentrator running at 1.5L/min. Resident #6 stated she was supposed to be at 4L/min, not 1.5. Physician orders were verified again and current order read 4L/min via nasal cannula continuous oxygen. At 10:58 AM on 1/7/16, Nurse #2 verified in Resident #6's chart the order for oxygen was 4L/min via NC. At 11:00 AM on 1/7/16 Nurse #2 visited Resident # 6's room and verified the oxygen concentrator was set at 1.5 L/min and stated she would check the chart again and clarify the order because the order she read was for 4 L/min. On 1/7/16, at 11:03 AM, the DON stated her expectation was that the 11-7 shift nurse was supposed to be the person checking the oxygen tubing, changing tubing, water bottles, etc., but she expected all shifts to verify the oxygen rate and check the concentrator settings. O 1/7/16 at 12:20 PM, Resident #6's oxygen concentrator was set back to 4 L/min via NC. At 1/7/16 at 12:35 PM the DON stated her expectation was for the nurses to immediately correct the oxygen dosage if they found the resident was receiving the incorrect amount of oxygen.	F 309		

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F 309	Continued From page 3	F 309		

3. Resident #248 was admitted to the facility on 11/18/2015 status post hospitalization for acute respiratory distress. Her diagnosis history included CHF, acute respiratory failure with hypercapnia (A condition of abnormally elevated carbon dioxide (CO 2) levels in the blood.) atrial fibrillation, and asthma.
MDS information, last dated 12/16/15, indicated that Resident #248 was cognitively intact and independent or only required supervision with ADLs.
A review of Resident #248's chart showed physician orders for oxygen saturation rate (O2 sats) to be monitored every four hours during the day and to keep the resident off of O2 if O2 sats were greater than 92% with a start date of 12/11/15 and a revision date of 12/23/15. The order did not indicate the rate or amount of O2 the resident was supposed to be administered.

On 1/6/16 at 4:55 PM, the occupational therapist who worked with Resident #248 reported that she did not go by any order in chart when she documented on the resident's respiratory status in her assessment. She had just looked at O2 concentrator when resident was being evaluated and it was set at 3L/min.

On 1/7/16 at 10:00 AM, Nurse #3 reported she was not sure what Resident #248's regular order for O2 was and was not sure why there was not an order or any documentation of the amount of O2 she was supposed to receive on a regular basis in the chart or the electronic medical record. She reported that the resident's concentrator had been set at 3L/min whenever she checked it at the beginning of her shifts.

On 1/7/16 at 1:20 PM, the DON and Corporate

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F 309	Continued From page 4 Nurse Consultant stated they were unable to find an order on Resident #248's chart for the amount of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen to be administered. Based on record review, resident and staff interviews, and observations, the facility failed to ensure there was a clear order for oxygen and it was being administered as ordered by the physician for 3 of 3 residents reviewed for well-being Resident #31, Resident #6, Resident #248). Findings included: 1) Resident #31 was admitted to the facility on 10/14/14. Diagnoses included: Hypertension, Renal Failure, Diabetes Mellitus, Hyperlipidemia, Atrial Fibrillation, Polyneuropathy, and Chronic Kidney Disease. A review of the most recent Minimum Data Set (MDS) dated 10/29/15, indicated the resident is alert and oriented, and had a Brief Interview for Mental Status (BIMS) of 15. She required extensive to one person physical assistance with Activities of Daily Living (ADLs) and bed mobility, and required extensive to two person physical assistance with transfers. Oxygen use was not indicated on her MDS dated 10/29/15. The current care plan indicated the resident was on oxygen therapy. A record review indicated a physician's order dated 11/29/15 read, "Oxygen at 2 L/NC prn". During an observation on 1/6/16 at 2:30 pm, the resident's oxygen concentrator was set at 3	F 309		

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F 309	Continued From page 5	F 309		

Liters/minute (L/min) via nasal cannula (NC).
An interview with resident #31 on 1/6/16 at 2:30 pm was conducted. She indicated that she was supposed to receive 2 L/min, not 3 L/min.
An interview with nurse #1 was conducted on 1/6/16 at 2:50 pm, she indicated the resident's oxygen order was for 2 Liters of continuous oxygen per minute via nasal cannula.
An observation on 1/6/16 at 3:00 pm was made with nurse #1 present. Nurse #1 verified the oxygen concentrator for resident #31 was set at 3 Liters per minute and adjusted the oxygen concentrator to 2 Liters per minute.
An interview with nurse #1 was conducted on 1/6/16 at 3:50 pm. She indicated she checked the resident's oxygen concentrators on her unit every morning and the nurses assigned to the resident's should also check the resident's oxygen concentrator delivery level. She indicated there was no record of documentation to reflect this information, she stated, "I just know who to check". She indicated the resident received continuous oxygen because "she likes it on" , but verified the physician order was for "as needed ".
An interview was conducted with the Director of Nursing on 1/6/16 at 4:22 pm. She indicated her expectation was for each nurse to monitor the resident's oxygen concentrator settings.
2. Resident # 6 was admitted to the facility in August 2014 and was readmitted on 9/18/14 with a diagnosis history that included essential hypertension, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and hyperlipidemia.

The most recent Minimum Data Set (MDS), dated 10/30/15, indicated that resident # 6 was cognitively intact and received oxygen (O2) therapy. She was also care planned for O2

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therapy.

At 4:00 PM on 1/6/16 during an observation of Resident #6, along with Nurse #1, it was noted that her oxygen concentrator was set at 1.5 liters per minute (L/min). Nurse #1 stated she did not know the resident's order for oxygen because she was not the unit manager for the 200 hall station. Resident #6's orders were reviewed and showed O2 ordered at 4L/min via nasal cannula (NC).
On 1/7/16 at 10:55 AM, Resident #6 was sitting up in her wheelchair with oxygen concentrator running at 1.5L/min. Resident #6 stated she was supposed to be at 4L/min, not 1.5. Physician orders were verified again and current order read 4L/min via nasal cannula continuous oxygen.
At 10:58 AM on 1/7/16, Nurse #2 verified in Resident #6's chart the order for oxygen was 4L/min via NC.
At 11:00 AM on 1/7/16 Nurse #2 visited Resident # 6's room and verified the oxygen concentrator was set at 1.5 L/min and stated she would check the chart again and clarify the order because the order she read was for 4 L/min.
On 1/7/16, at 11:03 AM, the DON stated her expectation was that the 11-7 shift nurse was supposed to be the person checking the oxygen tubing, changing tubing, water bottles, etc., but she expected all shifts to verify the oxygen rate and check the concentrator settings.
O 1/7/16 at 12:20 PM, Resident #6's oxygen concentrator was set back to 4 L/min via NC.
At 1/7/16 at 12:35 PM the DON stated her expectation was for the nurses to immediately correct the oxygen dosage if they found the resident was receiving the incorrect amount of oxygen.
3. Resident #248 was admitted to the facility on 11/18/2015 status post hospitalization for acute

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F 309	Continued From page 7	F 309		

respiratory distress. Her diagnosis history included CHF, acute respiratory failure with hypercapnia (A condition of abnormally elevated carbon dioxide (CO 2) levels in the blood.) atrial fibrillation, and asthma.
MDS information, last dated 12/16/15, indicated that Resident #248 was cognitively intact and independent or only required supervision with ADLs.
A review of Resident #248's chart showed physician orders for oxygen saturation rate (O2 sats) to be monitored every four hours during the day and to keep the resident off of O2 if O2 sats were greater than 92% with a start date of 12/11/15 and a revision date of 12/23/15. The order did not indicate the rate or amount of O2 the resident was supposed to be administered.

On 1/6/16 at 4:55 PM, the occupational therapist who worked with Resident #248 reported that she did not go by any order in chart when she documented on the resident's respiratory status in her assessment. She had just looked at O2 concentrator when resident was being evaluated and it was set at 3L/min.

On 1/7/16 at 10:00 AM, Nurse #3 reported she was not sure what Resident #248's regular order for O2 was and was not sure why there was not an order or any documentation of the amount of O2 she was supposed to receive on a regular basis in the chart or the electronic medical record. She reported that the resident's concentrator had been set at 3L/min whenever she checked it at the beginning of her shifts.

On 1/7/16 at 1:20 PM, the DON and Corporate Nurse Consultant stated they were unable to find an order on Resident #248's chart for the amount

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

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F 309	Continued From page 8 of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen to be administered.	F 309		