STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/DURHAM	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 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 record review and staff interviews the facility failed to follow physician orders related to medication administration and blood sugar monitoring for three (Residents # 3, # 6, and # 10) of 10 sampled residents. The findings included: 1. Record review revealed Resident # 6 was admitted to the facility on 2/18/16 after being hospitalized for a left hip fracture. Review of the resident ' s physician orders, March 2016 electronic MAR (Medication Administration Record), and nursing notes revealed the following. On 2/26/16 an order was written for Requip XL (extended release) 2 mg (milligrams) to be administered daily. The medication was scheduled to be given as a bedtime dose on the MAR. According to the nursing notes, the resident did not receive his bedtime dose of Requip on 3/21/16 because the facility was waiting on the shipment from their pharmacy. During an interview with the DON (Director of Nursing) on 3/22/16 at 3:40 PM, the DON stated she would review why the pharmacy had not sent the Requip. A follow up interview was conducted with the DON on 3/23/16 at 11:15 AM. The DON stated she had talked to the pharmacy the previous evening. The DON stated she was told the medication was not sent because of insurance purposes. The DON stated she requested the medication be sent regardless and was delivered on the evening of 3/22/16 and	F 281	F281 Resident #6 was seen by the physician on 3/23/16 and no new orders were written. The facility Director of Nursing completed medication variance report related to the medication Requip on 3/22/16. Resident #3 and Resident #10 physician orders were reviewed by the attending physician to ensure, to include review frequency of resident accu checks on 4/2/16. The residents that have the potential to be affected by the deficient practice, an facility audit was completed of EMAR for previous thirty days to ensure resident who receive medications have those medication available in stock so they can be administered per order. The audit was completed by the Director of Nursing on 3/31/16. The facility Director of Nursing completed audit of resident identified with physician orders for accu checks to ensure that orders were being carried out, to include at correct time on 3/27/16-4/4/16. The facility licensed nurses have been	4/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/08/2016

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F 281	Continued From page 1 administered on the evening of 3/22/16. A pharmacist, who works for the pharmacy which supplies medications to the facility, was interviewed on 3/23/16 at 2:30 PM. The pharmacist stated the reason the pharmacy did not supply the Requip for the evening of 3/21/16 was because the facility should have had enough of medication from the 2/26/16 shipment. The pharmacist stated they had reviewed their dispensing records. The pharmacist stated the pharmacy sent 30 tablets of the resident ' s Requip on 2/26/16 and therefore the facility should have had five doses of medication on hand on when they ran out of the medication. Interview with the DON on 3/23/16 at 3:50 PM revealed she had verified by reviewing facility records that 30 doses of the resident ' s Requip medication were received by the facility on 2/26/16, but she had not been able to account for the missing pills which should have been available on 3/21/16. 2. Resident # 3 was admitted to the facility on 3/5/16 with multiple diagnoses. One of the resident ' s diagnoses included Diabetes Type II. Review of Resident # 3 ' s admission MDS (Minimum Data Set) assessment, dated 3/19/16, revealed the resident was cognitively intact. Review of the resident ' s medications revealed the resident received two oral medications and insulin to treat her diabetes. Review of the resident ' s current physician orders revealed an order for an accucheck (blood sugar check) before meals and at bedtime. The origination date of the accucheck order was 3/5/16. Review of the resident ' s blood sugars revealed the readings had ranged from 88 to 323 since admission. The resident was observed on 3/22/16 at 8:45 AM in her room and finished with her breakfast	F 281	re-educated beginning 3/22/16-4/9/16 on Medication Administration Policy to ensure that meds are re-ordered timely and the education covered emergency supplies, use of Omnicell, and after hours pharmacy to ensure residents receive their medication per physician orders. The licensed nurses were provided re-education of obtaining accu-checks at the designated time of the orders on 3/22/16 - 4/9/16, facility licensed staff that does not receive the re-education will be scheduled for the training prior to working next shift. Newly hired licensed nurses will receive the education during orientation. The Director of Nursing, Unit Coordinator and Staff Development Nurse will randomly review four to five resident EMARs to medications in cart to ensure medications are available weekly times four and monthly times two. The Director of Nursing or designee will complete one to two medication observations weekly times four and monthly times one to ensure that accu checks are being obtained per designated time on the physician orders. The Director of Nursing will report results of audits to the Quality Assurance committee (QAPI) meeting monthly for times two months for review and recommendation.	

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F 281	Continued From page 2	F 281		

meal. The tray was empty of a large portion of food and had been set aside by the resident. The resident ' s nurse (Nurse # 1) was observed to check the resident ' s blood sugar at this time. Interview with Nurse # 1 directly following this observation revealed the nurse was working for another nurse that day and was " running behind. "

Interview with Resident # 3 on 3/22/16 at 9:22 AM revealed her blood sugar checks were not consistently done before meals and the timing varied depending on which nurse was on duty. Interview with the facility DON (Director of Nursing) on 3/22/16 at 2:55 PM revealed meal trays for Resident # 1 ' s unit were routinely served between 7:50 AM and 8:15 AM.

3. Record review revealed Resident # 10 was admitted to the facility on 2/23/16 with multiple diagnoses. One of the resident ' s diagnoses was listed as Diabetes.

Review of the resident ' s admission MDS (Minimum Data Set) assessment revealed the resident was cognitively intact. The resident ' s name also appeared on a 3/22/16 list of residents whose interviews would be considered reliable by the facility.

Review of the resident ' s medications revealed the resident received three different oral medications to treat his Diabetes. Review of the resident ' s current physician orders revealed an order for an accucheck (blood sugar check) before meals and at bedtime. The origination date of the order was 2/23/16. Record review revealed the resident ' s blood sugar readings ranged from 93 to 293 since admission.

Resident # 10 was interviewed on 3/23/16 at 8:45 AM. Resident # 10 stated the facility nurses checked his blood sugar after meals approximately fifty to sixty percent of the time.

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure it was free of significant medication errors for one (Resident # 6) of five sampled residents in regards to a steroidal medication omission for six days. The findings included: Record review revealed Resident # 6 was admitted to the facility on 2/18/16 after being hospitalized for a left hip fracture. The resident had additional diagnoses which included cellulitis, edema, and ulcerative colitis. Review of the resident ' s progress notes, physician orders and March 2016 electronic MAR (Medication Administration Record) revealed the following details. On 3/15/16 the resident was seen by his physician who documented Resident # 6 had worsening of his lower extremity edema. The physician noted in her progress note Resident # 6 was receiving a daily 9 mg (milligram) dose of the diuretic, Bumex. An order was hand written by the physician on 3/15/16 to increase the Bumex from 9 mg every day to a dosage of 5 mg twice per day. According to the resident ' s previous orders, which had been written before 3/15/16, the resident was not receiving Bumex or its generic equivalent, Bumetanide. As of 3/15/16 the resident was receiving a steroidal medication used to treat his ulcerative colitis. The name of this medication was Budesonide and the dosage was 9 mg daily in a 24 hour extended release form. According to	F 333	F333 The medication orders for Resident #6 were reviewed and Bumex order was discontinued, and Bumetanide order was resumed at prior dosages. In order to identify other residents who could potentially be impacted by the alleged deficient practice, current facility residents medication orders were reviewed for last sixty days by Director of Nursing and designee (licensed nurses) on 3/23-3/31/16 to ensure that medication had been transcribed correctly and implemented. The results of the audit were documented on the F333 - Orders Transcribed Correctly Form. Systemic measures will be put in place to prevent recurrence of the alleged deficient practice by completing reviews and conducting random audits by the Director of Nursing and other Nursing Department Leadership as follows: All residents medications and orders will be reviewed at least monthly during the facility change over process by the Director of Nursing and designee (licensed nurses) for two months.	4/14/16

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F 333	Continued From page 4 the March MAR, on 3/15/16 the resident ' s 9 mg daily dose of Budesonide was discontinued. On 3/15/16 there was an entry made on the March 2016 MAR to administer Budesonide 5 mg in a 24 hour extended release form twice per day. Between the dates of 3/15/16 and 3/22/15 multiple nurses signed they administered this dosage of Budesonide. The DON (Director of Nursing) was accompanied to the medication cart on 3/22/16 at 3:40 PM where two nurses were standing between shift changes. The DON asked to see what medication the nurses had been administering for the order on the MAR which read Budesonide Extended Release 5 mg twice per day. No Budesonide medication was found on the cart by the nurses. One of the two nurses stated she had just returned to work that morning after being off duty for the week and had called the pharmacy because Budesonide didn ' t come in that strength. Interview with the resident ' s physician and DON (Director of Nursing) on 3/22/16 at 5:10 PM revealed there had been an error made on 3/15/16 when the order was written to increase the resident ' s Bumex. The physician clarified the resident was not on Bumex at the time when she wrote the order, and the similar spelling of the resident ' s colitis medication with the generic form of Bumex had contributed to the error which led to the resident not receiving his Budesonide. An interview was conducted on 3/23/16 at 11:15 AM with the DON. The DON stated she had talked to the nurses who had cared for Resident # 6 between the dates of 3/15/16 and 3/22/16 and validated they had not administered the resident ' s Budesonide on the following dates 3/16/16; 3/17/16, 3/18/16, 3/19/16, 3/20/16, and 3/21/16. Also the DON clarified the following details in	F 333	New physician orders from previous day will be reviewed daily by the Director of Nursing to ensure orders have been transcribed correctly and implemented for thirty days. The Director of Nursing will pull 1 to 2 random sample daily (various units) and review both the medication order as well as all associated documentation and recording of order for thirty days. The facility licensed nurses will receive re-education regarding prevention of medication errors 3/22/16-4/9/16 by Director of Nursing and Staff Development Coordinator. Newly hired licensed nurses will receive education during orientation. Licensed nurses that does not receive the re-education will be scheduled to receive the education prior to working next scheduled shift. The Director of Nursing will report results of audits to the Quality Assurance Committee (QAPI) meeting monthly for times two months for review and recommendation.	

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regards to the error. When the Bumex order had been hand written by the physician on 3/15/16, a nurse entered the order into the computer as Budesonide Extended Release 5 mg twice per day. This Budesonide order was transmitted electronically to the pharmacy which never received an order for Bumex. The Budesonide Extended Release 5 mg dosage was not ever filled by the pharmacy and sent to the facility because it was not supplied by the manufacturer in a 5 mg extended release strength. The nurses, who had documented they had administered the Budesonide 5 mg, made an error in documentation by not noting on the MAR that it was not given.

A pharmacist, who works for the pharmacy which supplies medications to the facility, was interviewed on 3/23/16 at 2:30 PM. The pharmacist stated it is the pharmacy ' s policy to question any medication order that needs clarification in order to be correctly filled. The pharmacist stated the pharmacy protocol is to do one of two things. They either fax the facility twice or they call and speak to a nurse and let the facility know the medication order needs to be clarified. The pharmacist stated that since the order had been clarified on 3/22/16, then pharmacy computer records were stored in a manner which prevented her from immediately accessing the records which pertained to the 3/15/16 Budesonide order. Therefore during the interview, the pharmacist was not able to state a date and time the pharmacy had notified the facility clarification was needed regarding the 3/15/16 order. The pharmacist stated this information could be obtained by pharmacy personnel at a later time.