

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff and record review, the facility failed to answer call lights and/or failed to provide incontinent care and failed to knock on the door and wait for an invitation to enter the resident's room for 3 of 12 sampled residents (Residents # 5, 7 and 8) who were reviewed for dignity and respect.</p> <p>Findings included: 1. Resident #8 was re-admitted to the facility on 3/3/16 with diagnoses that included hypertension and diabetes. Her 30 day Minimum Data Set, dated 4/7/16, identified the resident as cognitively impaired. She was coded as needing extensive to total assistance with personal hygiene and toilet use. The resident was identified as frequently incontinent of bladder and always incontinent of bowel. An observation was made during the initial tour of the facility beginning on 5/4/16 at 6:00 PM. As the 200 hall was approached, 5 call lights were on with one of the lights identified as Resident #8's. At 7:05 PM, the call light in Resident #8's room was observed to be on again. On interview at this time, Resident #8 stated she was wet and needed to be changed. She stated earlier when she had turned the call light on, the nursing assistant (NA) came in, turned the light off, but</p>	F 241	<p>Resident #8 skin checked by 200 hall nurse manager on 5/19/16 and reveals no areas.</p> <p>One to one inservicing occurred with NA #5 on 5/19/16 by the director of nursing. Inservice included the expectation of knocking on resident's door, introducing herself, and waiting to be invited in before entering, answering a call light when she sees it on even if the resident is not in her assignment, refraining from turning a call light off without meeting requested need, and her responsibility to report to a nurse or nursing supervisor if she came on her shift and found a resident that was heavily soiled.</p> <p>One to one inservicing occurred with housekeeping supervisor on 5/19/16 by the director of nursing on the expectation of knocking on resident's door, introducing himself, and asking if he can come in before entering.</p> <p>Resident #5 skin checked by 200 hall nurse manager on 5/19/16 and reveals no areas.</p>	5/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/26/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 1</p> <p>did not provide care. She stated it made her sad when the staff ignored her call light. NA #5 entered the resident's room at this time without knocking, speaking or waiting for an invitation into the room. NA #5 did not ask Resident #8 what she needed or acknowledge the call light was on. She went to a large plastic bag in the resident's wheelchair, removed supplies and carried those supplies to a room across the hall. At 7:10 PM, the NA returned to the resident's room. She still did not acknowledge Resident #8's call bell was on, until surveyor intervention. The NA added she was unable to provide Resident #8's care at that time because she was with another resident. NA #5 returned to the resident's room at approximately 7:20 PM and provided the incontinent care. There was no odor noted when the brief was removed. NA #5 acknowledged the resident's brief was wet. Her skin was reddened and the imprint of the wrinkles in the linen were noted in the resident's skin. Moisture barrier was applied prior to placing a clean brief. She stated she had last provided incontinent care at 4:30 PM for Resident #8. NA #5 added when she arrived at 3:00 PM, she often found residents, especially those that were up all day, with urine that had penetrated their brief, clothing and into the wheelchair seats. She did not state she had reported the residents' incontinence to administrative staff and had no reason for ignoring Resident #8's light or not knocking when entering the room.</p> <p>2. Resident #7 was admitted to the facility on 4/22/16 with diagnoses that included a fracture, muscle weakness, depression, hypertension and difficulty walking. The 4/29/16 Admission MDS found the resident cognitively intact. Extensive assistance was</p>	F 241	<p>Responsible party of resident #5 was contacted on 5/20/16 by the assistant director of nursing related to his concerns of alleged neglect. Investigation was initiated on 5/20/16 and completed on 5/24/16.</p> <p>In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-services will include the expectation of knocking on resident's door, introducing yourself and waiting to be invited in before entering, it is everyone's responsibility to answer call lights, answering a call light when you see it on even if resident is not in your assignment, refraining from turning a call light off without meeting requested need, and the responsibility to report to a nurse or nursing supervisor if you arrive to your shift and find a resident to be heavily soiled. In-servicing will also include the expectation of timely incontinence care.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager, and/or ambassadors to include social worker assistant, activities director and activities assistant, medical records director will interview 2-3 sampled residents per hall weekly times four then monthly times two to ensure that staff are knocking on their doors, introducing themselves and waiting to be invited in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 2</p> <p>needed for dressing, toilet use and personal hygiene.</p> <p>On 5/5/16 at 8:25 AM, while the resident was being interviewed, the Housekeeping Supervisor entered the room without knocking and began cleaning the room although Resident #7 was involved in a conversation.</p> <p>Nurse #2 was interviewed on 5/5/16 at 1:53 PM and stated Resident #7 was oriented to person and place.</p> <p>The Housekeeping Supervisor was interviewed on 5/6/16 at 11:17 AM. The supervisor stated he had been taught to knock on the door and say housekeeping and ask to clean the room. He added he knew he was supposed to wait for the resident's invitation to enter the room. The housekeeping supervisor acknowledged he had not knocked on Resident #7's door, but thought he had said " housekeeping ". He acknowledged he had not waited for an invitation to enter the room and added even with the surveyor in the room he had not realized the resident was having a conversation.</p> <p>An interview was held with Resident #7 on 5/6/16 at 10:29 AM. Resident #7 stated he remembered when the housekeeper came into the room while he was having a conversation. The resident added it was not unusual for staff to walk in without knocking and he saw that as just another way the staff proved what they needed to do was more important than the resident's needs.</p> <p>The Director of Nursing (DON) was interviewed on 5/6/16 at 2:25 PM. She stated staff were not taught to always knock on doors and ask for entrance if the door to the resident ' s room was open.</p> <p>3. Resident #5 was admitted to the facility on 6/10/15 with diagnoses that included diabetes, depression, dementia without behaviors and</p>	F 241	<p>before entering, and answering their call lights in a timely manner. Sampled residents will also be asked if they are receiving timely incontinent care.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will perform rounds and observations that incontinent care has been provided to 2-3 sampled residents per hall weekly times four then monthly times two to ensure that staff are changing residents in a timely manner.</p> <p>The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	<p>Continued From page 3</p> <p>Parkinson ' s disease.</p> <p>Review of the 4/12/16 Significant Change Minimum Data Set (MDS) MDS indicated Resident #5 was moderately cognitively impaired. No behaviors or rejection of care was recorded. The resident required extensive assistance with transfer and personal hygiene and required total assistance with toilet use. Resident #5 was identified as frequently incontinent of bowel and bladder.</p> <p>An interview with the Responsible Party (RP) and another family member was held on 5/4/16 at 7:30 PM. The RP stated he felt Resident#5 was being neglected since she was not receiving showers or assistance with toileting. The RP stated the resident had been left wet to the point when he sat on the bed his pants were wet with urine. He stated he would come to visit and the resident would smell of urine. Today, he added, another family member came to visit the resident and before they got to the room, they heard the resident screaming and yelling help for someone to assist her to the bathroom. After the family member arrived, it still took at least 25 minutes for staff to respond.</p> <p>The visiting family member was interviewed by phone on 5/4/16 at 7:40 PM. She stated she had arrived at the facility that day about 1:40 PM. When she was coming down the hall, she heard the resident crying and screaming help. Resident #5 told the family member she could not get help to toilet. The family member stated she approached staff that was in the hall (name unknown) and was told they would find the Nursing Assistant (NA) assigned to the resident. After waiting 25 minutes, she went to nurse's station and saw 2 nurses and asked if they would assist Resident #5 to the toilet. All total, she stated it was about 45 minutes before assistance</p>	F 241			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 4 arrived for the resident. She stated during this time, one NA told her she had heard the resident crying for a while, but had to leave for an appointment, so she could not help. The family member could not identify that NA and added the NA had not given a reason for not helping when she heard the resident crying earlier. The interview continued with the 2 family members that had started at 7:30 PM. They stated this was not the first time the resident had complained of not being able to get help to toilet. The family members stated they had reported their care issue concerns and for about a month, care had improved. They reported care had been horrible the last few weeks adding the resident had been found with urine that had soaked through Resident #5's clothes, briefs and even leaving her wheelchair seat wet. Nurse #1 was interviewed on 5/5/16 at 11:49 PM. Nurse #1 stated she was the primary Monday through Friday nurse for Resident #5. She described Resident #5 as requiring assistance with toileting and added she was continent as long as she got the assistance required. The nurse stated it was Resident #5's usual behavior to cry and scream when she needed assistance with toilet use. Nurse #5 acknowledged she was the nurse that had assisted the resident to the bathroom earlier in the day, but denied she had heard her crying and screaming for help prior to the family member asking her to assist the resident. Nurse #1 stated Resident #5 was alert, oriented and reliable in her stories. NA # 1 and NA #2 were observed assisting Resident #5 on 5/6/16 at 10:08 AM. NA #1 acknowledged there was a brown ring on the pad and the pad was wet that had been under Resident #5, but added she had provided incontinent care at 8:00 AM. The NA stated she	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 241	Continued From page 5 had not noticed the pad under the resident had been wet, but stated it must have been if the brown ring was there now. The Director of Nursing was interviewed on 5/6/16 at 3:00 PM. She stated it took more than 2 hours for urine to dry and produce a brown ring.	F 241			
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 interviews with resident, Responsible Party (RP) and staff and record review, the facility failed to complete an admission assessment, obtain vital signs and provide pain medication for 1 of 3 sampled residents (Resident #1) who was reviewed for care received after an admission. Findings included: Resident #1 was admitted and discharged on 3/26/16. Admission diagnoses, obtained from the 3/26/16 hospital discharge summary included fractured ribs, fractured vertebra and a fractured patella. Review of the resident's electronic medical record, with an admission date of 3/26/16, failed to reveal documentation of an admission	F 309	Resident #1 is no longer at facility. One to one inservicing occurred with nurse #2 on 5/18/16 by director of nursing on the expectation of performing timely initial nursing assessment on new admissions to include vital signs and addressing pain and procedure for obtaining medications from the pharmacy after hours and on weekends and what to do if medication not available. In-servicing also included examples to improve customer service by being aware of how we communicate information to residents and families. In-servicing by the staff development coordinator or designee began on 5/18/16	5/26/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 6</p> <p>assessment, physician's orders or admission vital signs. There were no nursing notes present in the electronic medical record.</p> <p>The RP for Resident #1 was interviewed by phone on 5/5/16 at 9:56 AM. He stated he met Resident #1 around 2:00-2:30 PM on the day of admission. After settling her into her room, he left the facility. Later that day, he received a call from another family member telling him Resident #1 had decided to leave. The RP added when he arrived, he asked when the resident could get her pain medication. The nurse (name unknown) told him it would be Monday before medications were received. He stated after talking with the resident and finding out it would be Monday before she received her medications, the two of them decided she would be better at home. The RP stated he then asked the nurse what he needed to do to take the resident home and the nurse replied, "Nothing. You can put her in the back of the car because she was never signed in".</p> <p>Nurse #2 was interviewed on 5/5/16 at 4:05 PM. She remembered Resident #1 and acknowledged she had worked the 3-11 shift on the day the resident was admitted to the facility. The nurse added she was unsure of what time the resident arrived at the facility, but Resident #1 was already in her room when she, Nurse #2, arrived for work at 3:00 PM. Nurse #2 stated the process for getting medications for newly admitted residents included inputting medications from the hospital discharge summary into the electronic medical record. She added at that point, the list of medications was electronically transmitted to the pharmacy for delivery. Nurse #2 added the facility's pharmacy was not open on weekends</p>	F 309	<p>and will be completed by 5/26/16/ for current licensed nurses. Newly hired licensed nurses will be inserviced during new hire orientation and all other licensed nurses will receive the inservices prior to working their next shift on the expectation of performing timely initial nursing assessment on new new admissions to include vital signs, offering hydration in a timely manner, addressing pain, and the procedure for obtaining medications from the pharmacy after hours and on weekends and what to do if medication not available. In-servicing also included examples to improve customer service by being aware of how we communicate information to residents and families. In-service on the importance and expectation of giving shift to shift report between nurses and shifts was included.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will audit admissions for the last 30 days beginning on 5/20/16 to ensure all have received the nursing assessment and baseline vital signs and that all medications are available.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will monitor all new admissions beginning 5/20/16 weekly times four then monthly times two to ensure the initial assessment was completed to include vital signs and that all medications are available.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 7</p> <p>and the only medications available to residents would be in the facility's emergency kits. The nurse added Resident #1 requested pain medication, but stated at the time of the request, she had not had time to enter the resident's information into the system. She added when she did get the medications into the system, she discovered she did not have the correct strength available. The RP requested she call the physician for clarification, but Resident #1 declined. The nurse stated if the resident had been on a medication that was not in the emergency medication kit, she would have borrowed the needed medication, but would not have gotten the resident's supply of medications until Monday. The nurse stated she did not get report concerning Resident #1 from the 7-3 nurse, identified as Nurse #3. She added she found Resident #1's admission packet from the hospital on top of the cart waiting for her. Nurse #2 acknowledged she had not taken Resident #1's vital signs and had not completed an assessment because staffing was short and she had other tasks to complete. She added with no help on weekends, it's tough to get all jobs completed.</p> <p>A telephone interview was held with Nurse #3 on 5/6/16 at 7:53 AM. He stated he remembered nothing about Resident #1 or the day she was admitted.</p> <p>A call was made to the hospital discharge planner on 5/6/16 at 9:15 AM. The phone call was not returned.</p> <p>A telephone interview was held with John Glennon, the facility's occupational therapist on 5/6/16 at 1:55 PM. He stated he completed an Occupational Assessment on Resident #1 on the day of admission.</p> <p>The Director of Nursing was interviewed on</p>	F 309	<p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will complete observation of shift to shift report on various shifts weekly times four then monthly times two to ensure that shift to shift report is occurring between nurses each shift.</p> <p>The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 8 5/6/16 at 3:06 PM. She stated the responsibility of admission assessments and vital signs belonged to the nurse on duty at the time of admission. The DON added if a resident was admitted close to shift change, the nurses from the 2 shifts may share the duties. She stated during the week, medications needed to be to the pharmacy by 5:00 PM for same day deliver, but added if needed a back up pharmacy was available for medication delivery. The DON stated admission medications were taken from the hospital discharge summary, verified with the primary care physician and entered into the electronic medical record. She stated with Resident #1's fractures, she would have expected the Resident to receive the pain medications when she requested. The DON reviewed the resident's medication list and acknowledged the ordered pain medication was located in the facility's emergency narcotic box. She stated she would have expected the resident to have her vital signs obtained and a nursing admission assessment to have been completed. Resident #1 was interviewed by phone on 5/6/16 at 3:29 PM. She stated on the day of admission to the facility, she left the hospital at approximately 2:00 PM and arrived to the facility before 2:30 PM. Nurse #2 came into her room to introduce herself and requested basic information so a dinner tray could be ordered. The resident stated Nurse #2 did not do an assessment and her vital signs were not taken. At 3:00 PM, she requested pain medication. Nurse #2 responded she had not entered her orders into the electronic medical record, therefore, she would not be able to have her medication. Resident #1 stated she later asked again for pain medication and Nurse #2 again told her she had not had time to enter the information into the electronic medical record.	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 9 At this point, Resident #1 stated Nurse #2 told her it would be Monday before she received her medications. Resident #1 stated it had been her decision to enter the facility for rehabilitation and it was her decision to leave in part due to lack of medication and assessment. An Admission Medication Administration Record (MAR) was presented by the Director of Nursing (DON) on 5/6/16 at 4:00 PM. She was unaware how the MAR could be printed without the medications having been entered into the electronic medical record. The DON acknowledged the pain medication that had been ordered for Resident #1 was available in the facility's emergency narcotic box and the resident would have been able to receive that medication. She added with the use of the facility's back up pharmacy, the resident's routine medication would have been available on the day of admission and she was unsure why the nurse told the resident and family medications would not arrive until Monday.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, residents, families and staff interviews and record review, the facility failed to provide bathing and/or incontinent care	F 312	Resident #7 is no longer in facility but did receive a shower on 5/5/16.	5/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	<p>Continued From page 10</p> <p>to 2 of 9 sampled residents (Residents # 7 and 8) reviewed for activities of daily living.</p> <p>Findings included:</p> <p>1. Resident #8 was re-admitted to the facility on 3/3/16 with diagnoses that included hypertension and diabetes. Her 30 day Minimum Data Set identified the resident as cognitively impaired. She was coded as needing extensive to total assistance with personal hygiene and toilet use. The resident was identified as frequently incontinent of bladder and always incontinent of bowel. An observation was made during the initial tour of the facility beginning on 5/4/16 at 6:00 PM. As the 200 hall was approached, approximately 5 call lights were on with one of the lights identified as Resident #8's. At 7:05 PM, the call light in Resident #8's room was observed to be on again. On interview at this time, Resident #8 stated she was wet and needed to be changed. She stated earlier when she had turned the call light on, the nursing assistant (NA) came in, turned the light off, but did not provide care. NA #5 entered the resident's room at this time without knocking, speaking or waiting for an invitation into the room. NA #5 did not ask Resident #8 what she needed or acknowledge the call light was on. With surveyor intervention, the NA added she was unable to provide Resident #8's care at that time because she was with another resident. NA #5 returned to the resident's room at approximately 7:20 PM and provided the incontinent care. The NA removed the resident's brief. While there was no odor present, the NA acknowledged Resident #8 was wet. She stated she had last provided incontinent care at 4:30 PM to Resident #8. NA #5 added when she arrived at 3:00 PM, she often</p>	F 312	<p>Resident #8 skin checked by 200 hall nurse manager on 5/19/16 and reveals no areas.</p> <p>One to one inservicing occurred with NA #5 on 5/19/16 by director of nursing. Inservice included the expectation of knocking on resident's door, introducing herself, and waiting to be invited in before entering, answering a call light when she sees it on even if the resident is not in her assignment, refraining from turning a call light off without meeting requested need, and her responsibility to report to a nurse or nursing supervisor if she came on her shift and found a resident that was heavily soiled.</p> <p>In-servicing by the staff development coordinator began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-services will include the expectation of knocking on resident's door, introducing yourself and waiting to be invited in before entering, it is everyone's responsibility to answer call lights, answering a call light when you see it on even if resident is not in your assignment, and the responsibility to report to a nurse or nursing supervisor if you arrive to your shift and find a resident to be heavily soiled. In-servicing will also include the expectation of timely incontinent care.</p> <p>One to one inservicing occurred with NA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	<p>Continued From page 11</p> <p>found residents, especially those that were up all day, with urine that had penetrated their brief, clothing and into the wheelchair seats.</p> <p>2. Resident #7 was admitted to the facility on 4/22/16 with diagnoses that included a fracture, muscle weakness, depression, hypertension and difficulty walking.</p> <p>The 4/29/16 Admission Minimum Data Set (MDS) identified the resident cognitively intact. Extensive assistance was needed for dressing, toilet use and personal hygiene. The MDS indicated it was very important for Resident #7 to choose whether he got a bed bath, shower or tub bath and was important to choose what clothing to wear. The care plan had not yet been developed.</p> <p>Resident #7 and a family member were interviewed on 5/4/16 at 8:00 PM. Resident #7 stated he was having problems getting a bath. He added on Monday, he had asked to be bathed 3 times, did not receive a bath or a shower. The resident stated he was bathed by his family member when he came to visit. The family member confirmed he had bathed the resident during his visit on Monday. Resident #7 stated he had no offers of a shower since admission but thought a shower would feel good and he would like one.</p> <p>On 5/5/16 at 8:25 AM, the resident was interviewed and stated he had not had his bath. At 12:15 PM, the resident was observed sitting on the side of the bed eating lunch, wearing the same clothing he had been wearing at 8:25 AM. He stated he had not received his bath. Resident #7 stated, "what does a man have to do around here to get a bath"?</p> <p>Nurse #2 was interviewed on 5/5/16 at 1:53 PM. The nurse confirmed Resident #7 was alert and oriented and would be able to correctly relay if he</p>	F 312	<p>#4 on 5/23/16 by director of nursing on what she should do when she cannot get to her assigned duties and needs assistance.</p> <p>One to one inservicing occurred with nurse #2 on 5/23/16 by director of nursing on what she should do when her nursing assistant cannot get to her assigned duties timely.</p> <p>In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include what employees should do when they or their nursing assistants are in need of assistance and/or cannot get to their assigned duties timely. In-servicing will also include the expectation that showers will be given, that it is a resident's preference when they receive a shower and the process for nurses to validate that showers have been offered and received and the reporting and documenting of that information.</p> <p>100% audit was completed on 5/24/16 for all residents in the facility to make sure all residents were assigned to the shower schedule to ensure that they all will receive a shower.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 12 had received a bath or shower. The nurse stated she worked with Resident #7 on the 7 to 3 shift Monday through Friday and added he or his family had not verbalized any care issues. The nurse added it was her expectation for the residents on her assignment to be bathed and dressed before lunch. She stated she was unaware the resident had not been bathed that day. Nurse #2 reported that Nursing Assistant (NA) #4 was assigned to care for Resident #7 that day. She added NA #4 was new and this was her first time working alone on the floor. At 2:15 PM, Resident #7 was seen wheeling himself in the hall returning from therapy. Nurse #2 intervened and assisted the resident to his room. An interview was held with the resident and the nurse on 5/5/16 at 2:15 PM. Resident #7 confirmed to the Nurse he had not had a bath that day. The nurse informed the resident she would get the NA to bathe him. NA #4 was interviewed on 5/5/16 at 2:31 PM. She acknowledged she was assigned to care for Resident #7. She stated this was her third day working the floor and her first day working alone. The NA stated she had 16 residents to care for and had not had time to bathe Resident #7. The NA stated she had arrived for work at 7:00 AM and received one assignment. She added around 8:00 AM, she received a new assignment. The NA stated she had not assisted Resident #7 with his bath because she thought someone else had bathed the resident. An interview was held with Resident #7 and a family member on 5/5/16 at 4:04 PM. The resident stated he still had not received a bath. He stated he hated to keep complaining about not getting a bath and he appreciated his family member bathing him, but it was not the family member's responsibility. The family member	F 312	manager began reviewing shower schedule on 5/20/16 to ensure all resident's have a schedule and that the schedule they have is their preference. Review will be completed by 5/26/16 then will be reviewed with new admissions to the facility at time of admission to ensure the schedule meets their preference. Nurses will validate that showers were offered, given and/or refused per assignment daily after completion of nurse manager review and will document that shower was offered and received or refused on the 24hour report. Nurse will be responsible to document information in point click care as well. Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will validate with the resident and/or resident's nurse to ensure that shower was given per facility schedule, that information was documented on the 24 hour report and in point click care 5 times weekly times four then monthly times two. The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 312	Continued From page 13 stated he had been bathing the resident at least every other day since his admission due to the fact Resident #7 reported staff was not bathing him. A 4:20 PM on 5/5/16, Nurse #2 was interviewed again. She stated she had told the NA to make sure she had bathed the resident. She stated she was sure the new NA was overwhelmed with her assignment today since it was her first day working alone and her 3rd day of working on the floor. At 4:30 PM on 5/5/16, the Director of Nursing was interviewed and made aware the resident had not been bathed. She stated she would immediately make sure Resident #7 received a shower.	F 312			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353		5/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 14 duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff interviews and record review, the facility failed to assure adequate staffing was available to provide bathing for 1 of 9 sampled resident (Resident #7) and incontinent care for 3 of 9 sampled residents (Resident #8, Resident #2 & Resident #12) who was dependent on staff for activities of daily living (ADLs) and failed to provide adequate staff to administer pain medication and an admission assessment for 1 of 3 sampled residents (Resident #1) reviewed for a recent admission. Findings included: 1. Resident #1 was admitted and discharged on 3/26/16 with diagnoses that included vertebral fractures, patella fractures and rib fractures. There were no nurse's notes or assessments in the resident's electronic records. Review of the facility Grievance Log from January 2016 through April 2016 revealed approximately 50% of the grievances received in any month related to activities of daily living (ADL) issues. Nurse #6 was interviewed on 5/4/16 at 7:05 PM. She stated staffing was ok on some days and some days not. She added the nurses tried to help the nursing assistants (NA), but when the nurses helped the NAs, that put them behind in their tasks. An interview was held with NA #3 on 5/6/16 at 6:55 AM. She stated normally there was enough staff, but at times they had to work with 1-2 NAs for her assigned hall. Stated during those times, the NAs on duty would have to pick up other	F 353	Resident #7 is no longer in facility but did receive a shower on 5/5/16. Resident #8 skin checked by 200 hall nurse manager on 5/19/16 and reveals no areas. Resident #2 skin checked by 200 hall nurse manager on 5/20/16 and reveals no areas. Resident #12 is no longer in facility but concern voiced on 2/11/16 and addressed by 200 hall unit manager related to untimely incontinent care. Responsible party was satisfied with outcome of actions at the time. In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include what employees should do when they or their nursing assistants are in need of assistance and/or cannot get to their assigned duties timely. In-servicing will also include the expectation that showers will be given, that it is a resident's preference when they receive a shower and the process for nurses to validate that showers have been		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 15 residents. The NA added the nurses helped as they could.. NA #3 stated she was able to get everything done, but would have to chart as she was eating and drinking her scheduled meal. She stated she had received complaints from residents and families about long call bell response and residents being left wet for long periods of time. On 5/6/16 at 7:13 AM, Nurse#7 was interviewed. She stated she was not sure if nurses were short, but confirmed she thought NAs worked short. The nurse added it was not because of how NAs were staffed, but because of call outs. She stated she thought the scheduler would try to find replacements, but if replacements were not found, staff just worked with what they had. Nurse #2 was interviewed on 5/5/16 at 4:05 PM. The nurse stated when she arrived for work at 3:00 PM on 3/26/16, Resident #1 was already in her room. She stated she had not received report from Nurse #3, but he had thrown Resident #1's hospital discharge information on top of the medication cart. The nurse stated Resident #1 requested pain medication and she was unable to give the medication because she had not had time to enter the resident's information into the electronic medical record and transferred the information to the pharmacy. Nurse #2 acknowledged she had not obtained vital signs from the resident and had not completed an initial nursing admission assessment on Resident #2. She stated staffing was short that day and she had other tasks to complete. The nurse added with no help on the weekend, it is tough to do it all. On 5/6/16 at 9:35 AM, an interview was held with a family member that requested not to be identified. She stated several NAs (names given) had worked the previous evening and were again	F 353	offered and received and the reporting and documenting of that information. Nurses will validate that showers were given per assignment daily at the beginning of completion of nurse manager review and will document that shower was offered and received or refused on the 24hour report. Nurse will be responsible to document information in point click care as well. Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will validate with the resident and/or resident's nurse to ensure that shower was given per facility schedule, that information was documented on the 24 hour report and in point click care 5 times weekly times four then monthly times two. In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include what employees should do when they or their nursing assistants are in need of assistance and/or cannot get to their assigned duties timely. In-servicing will also include the expectation of timely incontinence care. Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 16 working the day shift. She stated 2 of those NAs present told her how tired they were. NA #8 was interviewed on 5/6/16 at 10:43 AM. She stated the facility's scheduler had sent her text requesting help during the 7 to 3 shift. She stated when the 7-3 shift was short, NAs would be assigned 16 to 17 resident's apiece. NA #8 added that recently NA #9 had quit because she had been assigned 19 residents to care for on the 7-3 shift. NA #8 stated the schedule told her she really needed help because "state" was in the building. The NA added when staffing is short, it's difficult or impossible to provide adequate incontinent care or provide showers to residents. A telephone interview was held with Resident #1 on 5/6/16 at 3:43 PM. She stated she left the hospital at 2:00 PM so her arrival at the facility was approximately 2:15 PM. She stated Nurse #2 was the only nurse she saw during her stay on 3/26/16. The resident added no vital signs were taken, which concerned her since the transport team from the hospital had told her that her blood pressure was elevated. She added she was also concerned that no physical assessment was completed by Nurse #2. Resident #1 stated she had not received requested pain medication and after asking staff several times to bring her water, her room-mate's visitor finally got water for her. Nurse #5 was interviewed on 5/6/16 at 1:41 PM. Nurse #5 confirmed she was responsible for staff scheduling. She denied any staffing issues involving the NAs. The nurse added when a NA was hired, there telephone number was entered into a computerized scheduling program. When additional staff was needed, a text message was automatically sent to all NAs. Additionally, Nurse #5 stated she would personally call and/or text the NAs to see who may be available. Nurse #5 stated if the NAs called would not or could not fill	F 353	hall nurse manager, 400 and 500 nurse manager will perform rounds and observations that incontinent care has been provided to 2-3 sampled residents per hall weekly times four then monthly times two to ensure that staff are changing residents in a timely manner. Scheduler, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager and licensed nurses will be inserviced beginning on 5/20/16 and completed on 5/26/16 by the staff development coordinator or designee on the importance and expectation that they are responsible to validate staffing patterns at the beginning of every shift to ensure the number of nursing assistants on a specific assignment is appropriate for the acuity of the residents on the assignment and that they are to make changes where necessary. Newly hired licensed nurses will be inserviced during new hire orientation and all other licensed nurses will receive the inservices prior to working their next shifts. In-servicing by the staff development coordinator or designee began on 5/20/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservice prior to working their next shift. In-service will include the proper call out procedure and the procedure that should occur if a staff member must leave the shift early.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 17 in vacant positions, nurses would work in those positions. The nurse reviewed the Grievance Log from January 2016 through April 2016 and stated she had no reason for the high number of ADL concerns. 2. Resident #7 was admitted on 4/22/16 with diagnoses that included generalized muscle weakness, difficulty walking and a fracture. The 4/29/16 Admission Minimum Data Set (MDS) found the resident cognitively intact. Extensive assistance was needed for dressing, toilet use and personal hygiene. The resident indicated it was very important to him to choose whether he got a bed bath, shower or tub bath and was important to choose what clothing to wear. The care plan had not yet been developed. Resident #7 and a family member were interviewed on 5/4/16 at 8:00 PM. Resident #7 stated he was having problems getting staff to assist with bathing, adding on Monday, he had asked to be bathed 3 times. The resident stated his family member assisted him with a bath when he came for a visit. Resident #7 added he had not been offered a shower or received a shower since his admission, but would like a shower. Nurse #1 was interviewed on 5/5/16 at 11:49 AM. The nurse stated the hall she worked was labor intensive with a lot of dependent residents and not enough NAs to complete the work. She added if the nurses tried to help, it put them behind in giving medications. The Nurse stated she was aware residents were not always turned and positioned and provided incontinent care timely. The nurse stated one NA had left early the day before and she was not sure if someone took her place, but she knew for sure some of the NA's work was left undone. She stated she was sure, due to staffing, there have been times she was sure residents had soiled and wet	F 353	Director of nursing, scheduler and assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager and staff development coordinator will monitor and evaluate the needs of new hire employees to determine the need for extended orientation. Will evaluate and by observations and discussions with the new employee a couple of days after orientation and periodically to make sure they are comfortable with their progression. Evaluation will be documented on an audit. All licensed nurses were inserviced beginning on 5/27/16 and completed by 5/29/16. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. Inservice will include that nurses are responsible to validate at the beginning of their shift that all scheduled personnel are present. If an assigned employee is not present the nurse is to notify the scheduler at that time. The scheduler will either find appropriate coverage or notify nursing administration to include the director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, and/or 400 and 500 nurse manager to ensure the facility has adequate staffing. Director of nursing, scheduler and assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager and staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 18 themselves. On 5/5/16 at 8:25 AM, the resident was interviewed and stated he had not had his bath that morning. At 12:15, Resident #7 was again interviewed and stated no one had yet helped him with a bath. Nurse #2 was interviewed on 5/5/16 at 1:53 PM. She acknowledged Resident #7 was alert and oriented and would be reliable in stating if he had a bath or not. Nurse #2 was unaware Resident #7 had not received his bath that morning. She added there was not enough NAs and they were expected to care for a lot of residents that required total care. Nurse #2 stated she expected the residents in her assignment to be bathed and dressed prior to lunch adding the NA assigned to Resident #7 was new and this was her first day working alone. The nurse added the NAs were not able to complete rounds and provide timely incontinent care. Nurse #2 stated prior to today, she had not seen administrative staff and department heads feeding residents and passing meal trays. Expect residents to be bathed and dressed prior to lunch. Unaware he had not had a bath. The nurse relayed a story about another resident's family member finding them wet. When she assessed the resident, the nurse stated the resident had saturated her brief and the pad underneath the brief. Nurse #2 stated since the NAs had been busy, she provided the incontinent care. On 5/6/16 at 9:35 AM, an interview was held with a family member that requested not to be identified. Her family member lived on the same hall as Resident #7. She stated several NAs (names given) had worked the previous evening and were again working the day shift. She stated 2 of those NAs told her how tired they were. NA #8 was interviewed on 5/6/16 at 10:43 AM.	F 353	development coordinator will validate at the beginning of each shift with the facility nursing staff that all assigned personnel are in attendance and the facility has adequate staffing daily times 30 days, weekly times four, then monthly times two. The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 19 She stated the facility's scheduler had sent her text requesting help during the 7 to 3 shift. She stated when the 7-3 shift was short, NAs would be assigned 16 to 17 resident's apiece. NA #8 added that recently NA #9 had quit because she had been assigned 19 residents to care for on the 7-3 shift. NA #8 stated the schedule told her she really needed help because "state" was in the building. The NA added when staffing is short, it's difficult or impossible to provide adequate incontinent care or provide showers to residents. At 2:15 PM on 5/5/16, the resident was seen wheeling himself in the hall returning from therapy. An interview was held with the resident and the nurse on 5/5/16 at 2:15 PM. He stated he still had not had a bath. Cookie crumbs were seen in the resident's bed. His bedspread was on the floor under the bed. The resident stated his sheets needed to be changed since the "girl" this morning and spilled water all over the sheets. NA #4 was interviewed on 5/5/16 at 2:31 PM. The NA stated this was her third day working on the hall. On the two previous days, she had been trained on two other halls. Today, her third day, was her first day working alone. She stated she had only been a NA for about a month. The NA stated the hall she was assigned today was a heavy load and she had been assigned 16 residents. NA #4 acknowledged she had been assigned Resident #7. The NA stated she was instructed during orientation to have all of her residents bathed and dressed by lunch, but 11 of her 16 assigned residents required total care. She added prior to 11:30 AM, another NA had helped her. NA #4 stated she knew the facility was short, but she really tried to get things done. She stated since she had started working at the facility, there had been a lot of call outs that lead to changes in the assignment and the addition of	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 20</p> <p>more residents to the assignment of the NAs working.</p> <p>Nurse #4 was interviewed on 5/6/16 at 11:49 AM. Nurse #2 was the Unit Manager for some of the residents on her hall. The nurse reviewed a February 2016 concern she had written for another resident regarding lack of showers. She stated it was part of her responsibility to make sure showers and baths were being given. The nurse stated she had told the family there were issues with staffing and residents receiving showers. The nurse declined to elaborate on what she meant when she stated there had been issues with staffing and showers.</p> <p>Nurse #5 was interviewed on 5/6/16 at 1:41 PM. Nurse #5 confirmed she was responsible for staff scheduling. She denied any staffing issues involving the NAs. The nurse added when a NA was hired, there telephone number was entered into a computerized scheduling program. When additional staff was needed, a text message was automatically sent to all NAs. Additionally, Nurse #5 stated she would personally call and/or text the NAs to see who may be available. Nurse #5 stated if the NAs called would not or could not fill in vacant positions, nurses would work in those positions. The nurse reviewed the Grievance Log from January 2016 through April 2016 and stated she had no reason for the high number of ADL concerns.</p> <p>3. Resident #8 was re-admitted to the facility on 3/3/16 with diagnoses that included hypertension and diabetes.</p> <p>Her 30 day Minimum Data Set identified the resident as cognitively impaired. She was coded as needing extensive to total assistance with personal hygiene and toilet use. The resident was identified as frequently incontinent of bladder and always incontinent of bowel.</p>	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 21 An observation was made during the initial tour of the facility beginning on 5/4/16 at 6:00 PM. As the 200 hall was approached, approximately 5 call lights were on with one of the lights identified as Resident #8 ' s. At 7:05 PM, the call light in Resident #8 ' s room was observed to be on again. On interview at this time, Resident #8 stated she was wet and needed to be changed. She stated earlier when she had turned the call light on, the nursing assistant (NA) came in, turned the light off, but did not provide care. NA #5 entered the resident's room at this time without knocking, speaking or waiting for an invitation into the room. NA #5 did not ask Resident #8 what she needed or acknowledge the call light was on. At 7:10 PM, the NA returned to the resident's room and until surveyor intervention, still did not acknowledge Resident #8's call light was on. The NA added she was unable to provide Resident #8 ' s care at that time because she was with another resident. NA #5 returned to the resident ' s room at approximately 7:20 PM and provided the incontinent care. When the resident's brief was removed, while there was no odor, the NA confirmed the resident's brief was wet. She stated she had last provided incontinent care at 4:30 PM to Resident #8. NA #5 added when she arrived at 3:00 PM, she often found residents, especially those that were up all day, with urine that had penetrated their brief, clothing and into the wheelchair seats. Nurse #1 was interviewed on 5/5/16 at 11:49 AM. The nurse stated the hall she worked, the hall where Resident #8 lived, was labor intensive with a lot of dependent residents and not enough NAs to complete the work. She added if the nurses tried to help, it put them behind in giving medications. The Nurse stated she was aware residents were not always turned and positioned	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 22</p> <p>and provided incontinent care timely. The nurse stated one NA had left early the day before and she was not sure if someone took her place, but she knew for sure some of the NA's work was left undone. She stated she was sure, due to staffing, there have been times residents had soiled and wet themselves.</p> <p>Nurse #2 was interviewed on 5/5/16 at 1:53 PM. Nurse #2 stated there were not enough NAs and they were expected to care for a lot of residents that required total care. Nurse #2 stated she expected the residents in her assignment to be bathed and dressed prior to lunch. The nurse added the NAs were not able to complete rounds and provide timely incontinent care. Nurse #2 stated prior to today, she had not seen administrative staff and department heads feeding residents and passing meal trays. The nurse relayed a story about another resident's family member finding them wet. When she assessed the resident, the nurse stated the resident had saturated her brief and the pad underneath the brief. Nurse #2 stated since the NAs had been busy, she provided the incontinent care.</p> <p>On 5/6/16 at 9:35 AM, an interview was held with a family member that requested not to be identified. Her family member lived on the same hall as Resident #8. She stated several NAs (names given) had worked the previous evening and were again working the day shift. She stated 2 of those NAs told her how tired they were.</p> <p>NA #8 was interviewed on 5/6/16 at 10:43 AM. She stated the facility's scheduler had sent her text requesting help during the 7 to 3 shift. She stated when the 7-3 shift was short, NAs would be assigned 16 to 17 resident's apiece. NA #8 added that recently NA #9 had quit because she had been assigned 19 residents to care for on the</p>	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 23</p> <p>7-3 shift. NA #8 stated the schedule told her she really needed help because "state" was in the building. The NA added when staffing is short, it's difficult or impossible to provide adequate incontinent care or provide showers to residents. NA #4 was interviewed on 5/5/16 at 2:31 PM. The NA stated this was her third day working on the hall. On the two previous days, she had been trained on two other halls. Today, her third day, was her first day working alone. She stated she had only been a NA for about a month. The NA stated the hall she was assigned today was a heavy load and she had been assigned 16 residents. The NA stated she was instructed during orientation to have all of her residents bathed and dressed by lunch, but 11 of her 16 assigned residents required total care. She added prior to 11:30 AM, another NA had helped her. NA #4 stated she knew the facility was short, but she really tried to get things done. She stated since she had started working at the facility, there had been a lot of call outs that lead to changes in the assignment and the addition of more residents to the assignment of the NAs working.</p> <p>Nurse #4 was interviewed on 5/6/16 at 11:49 AM. Nurse #2 was the Unit Manager for some of the residents on her hall. The nurse reviewed a February 2016 concern she had written for another resident regarding lack of showers. She stated it was part of her responsibility to make sure showers and baths were being given. The nurse stated she had told the family there were issues with staffing and residents receiving showers. The nurse declined to elaborate on what she meant when she stated there had been issues with staffing and showers.</p> <p>Nurse #5 was interviewed on 5/6/16 at 1:41 PM. Nurse #5 confirmed she was responsible for staff</p>	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 24 scheduling. She denied any staffing issues involving the NAs. The nurse added when a NA was hired, there telephone number was entered into a computerized scheduling program. When additional staff was needed, a text message was automatically sent to all NAs. Additionally, Nurse #5 stated she would personally call and/or text the NAs to see who may be available. Nurse #5 stated if the NAs called would not or could not fill in vacant positions, nurses would work in those positions. The nurse reviewed the Grievance Log from January 2016 through April 2016 and stated she had no reason for the high number of ADL concerns. 4. Resident #2 was admitted to the facility on 1/25/16 with diagnoses which included cerebral infarct with left sided hemiplegia and hemiparesis, muscle weakness, difficulty walking, dysphagia, Alzheimer ' s disease and mild cognitive impairment. His most recent Minimum Data Set, a 60 day assessment dated 3/21/16, revealed he was cognitively intact with no behaviors. He needed extensive assistance with bed mobility, transfers, dressing and personal hygiene. His Care Plan revealed a concern for bladder incontinence. A review of the grievances revealed concerns were filed on 2/29/16, 3/7/16 and 3/31/16. In the grievance dated 3/7/16 the concern was that on 3/6/16 the 11:00 PM - 7:00 AM shift had not changed Resident #2 " until the end of their shift. His shirt was soaking wet. " In the 3/31/16 grievance the concern was that the NAs did not	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 25</p> <p>provide care on the 11:00 PM to 7:00 AM shift. A review of the nursing note written by Nurse #8 dated 3/24/16 revealed the resident 's sister complained that the resident was wet and soaked through his pad. The note went on to explain the nurse checked the resident who " was wet but not soaked and the pad was not wet. "</p> <p>On 5/5/16 at 11:40 AM Resident #2 stated he used a bed pan when he had a bowel movement but wore an adult brief for urine. He stated it may take 30 minutes to an hour before his call bell was answered.</p> <p>On 5/6/16 at 10:45 AM Nursing Assistant (NA) #8 reported Resident #2 was total care but he could help by standing and transferring into the bed. She stated he was a " heavy wetter " so she had to check him every 1 to 1.5 hours. NA #8 stated she had seen his bed wet and remembered when she went to check him because his light was on. She stated his family was present. NA #8 stated the sheets and his shirt were wet. She stated the " Chux pad " was stained and the fitted sheet had a brown ring on it. NA #8 added that this was not the first time this had happened and that the other time was when the NA did not know the resident was on her assignment. She then added that " sometimes they change the assignment but no one else tells everyone. " NA #8 then reported the resident told her he was put to bed around 2:30 PM and no one had touched him since. She stated this conversation was at 7:30 or 8:00 at night.</p> <p>NA #8 then stated Nurse #5 had sent her text requesting help today (5/6/16) during the 7:00 AM to 3:00 PM shift. She reported she usually worked the 3:00 PM-7:00 PM shift. She stated when the 7-3 shift was short, NAs would be assigned 16 to 17 residents apiece. NA #8 added that recently NA #9 had quit because she had been assigned</p>	F 353			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 26</p> <p>19 residents to care for on the 7-3 shift. NA #8 stated Nurse #5 told her she really needed help because "state" was in the building. NA 8 added when staffing was short, it was difficult or impossible to provide adequate incontinent care to residents.</p> <p>Nurse #5 was interviewed on 5/6/16 at 1:41 PM. Nurse #5 confirmed she was responsible for staff scheduling. She denied any staffing issues involving the NAs. The nurse added when a NA was hired, there telephone number was entered into a computerized scheduling program. When additional staff were needed, a text message was automatically sent to all NAs. Additionally, Nurse #5 stated she would personally call and/or text the NAs to see who may be available. Nurse #5 stated if the NAs called would not or could not fill in vacant positions, nurses would work in those positions. The nurse reviewed the Grievance Log from January 2016 through April 2016 and stated she had no reason for the high number of ADL concerns.</p> <p>5. Resident #12 was admitted 3/2/12 and readmitted 12/26/14 with diagnoses which included diabetes, cerebrovascular disease, chronic pain, dysphagia, lymphedema, peripheral vascular disease and joint pain. Her quarterly Minimum Data Set (MDS) dated 4/20/16 revealed she was severely cognitively impaired, required total assistance with all Activities of Daily living (ADLs) and was always incontinent of bladder and bowel.</p> <p>A review of the Grievances revealed a concern dated 2/11/16 stated a family member found Resident #12 was found at 10:30 AM " very soiled and bed linens soiled. "</p> <p>On 5/5/16 at 2:05 PM Nurse #2 stated there was an incident the day before yesterday at 8:00 or</p>	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 27 8:30 AM when Resident #12 was found " saturated " by a family member. She stated there was a brown ring on pad under the resident. She stated the sheet was not wet. Nurse #2 stated there were not enough NAs and they were expected to care for a lot of residents that required total care. Nurse #2 stated she expected the residents in her assignment to be bathed and dressed prior to lunch. The nurse added the NAs were not able to complete rounds and provide timely incontinent care. Nurse #2 stated prior to today, she had not seen administrative staff and department heads feeding residents and passing meal trays. On 5/5/16 at 2:30 PM NA #4 stated when she arrived she was assigned certain rooms but one hour later her assignment was changed but she did not know why. She stated staff have told her that people call out a lot. The NA stated the hall she was assigned today was a heavy load and she had been assigned 16 residents. The NA stated she was instructed during orientation to have all of her residents bathed and dressed by lunch, but 11 of her 16 assigned residents required total care. She added prior to 11:30 AM, another NA had helped her. NA #4 stated she knew the facility was short, but she really tried to get things done. She stated since she had started working at the facility, there had been a lot of call outs that lead to changes in the assignment and the addition of more residents to the assignment of the NAs working On 5/6/6 at 11:45 AM the family of Resident #12 reported during the visit on 5/3/16 they had found resident #12 soaked and a brown ring on the pad where it had dried. On 5/6/16 at 11:50 AM Nurse #4 stated Resident #12 was total care. She stated a family member reported to her on Tuesday (5/3/16) that the	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 28 resident was wet. She stated she observed the pad and it was brown.	F 353			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to have pain medication for 1 of 3 residents (Resident #1) reviewed for medications. Findings included: The resident was admitted and discharged on 3/26/16. There were no nurse's notes or	F 425	Resident #1 is no longer in the facility. One to one inservicing occurred with nurse #2 on 5/18/16 by director of nursing on the procedure for obtaining medications from the pharmacy after hours and on weekends and what to do if medication not available.	5/26/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	Continued From page 29 assessments in the resident's electronic records. Review of the 3/26/16 hospital discharge summary indicated the resident's diagnoses included compression fractures of the thoracic vertebra, patella fracture, rib fractures, pleural effusion, atelectasis, and acute respiratory failure. Resident #1's Responsible Party (RP) was interviewed by phone on 5/5/16 at 9:56 AM. The RP stated the resident had arrived at the facility between 2:00-2:30 PM on the day of admission. After getting the resident settled in, he left. Another family member arrived around 6:00 PM and called him telling him the resident had decided not to stay. The RP stated on his arrival back at the facility around 7:00 PM, one of the things he had asked the nurse about was the resident's pain medications. He stated the nurse (name unknown) told him the medications would not be received until Monday. He added since Resident #1 had multiple fractures and would not be receiving her pain medications until Monday, he and the resident decided she would be better at home with family taking care of her where she could get pain medication. He stated he asked the nurse what he had to do to take the resident home and she replied, "you don't have to do anything to leave, she was never signed in". He stated Resident #1 was placed in the back seat of the car and taken home. Nurse #2 was interviewed on 5/5/16 at 4:05 PM. While nurse #2 was unable to say what time Resident #1 had arrived at the facility on 3/26/16, she stated the resident was in the facility when she arrived for work at 3:00 PM. The nurse stated the process for receiving medications for newly admitted residents included logging all medications into the electronic medical record. The nurse all after entering the medications, using the medications listed on the discharge	F 425	In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include the procedure for obtaining medications from the pharmacy after hours and on weekends and what to do if medication not available. Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager will monitor all new admissions beginning 5/20/16 weekly times four then monthly times two to ensure that all medications are available. The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	<p>Continued From page 30</p> <p>summary, the order was electronically sent to the pharmacy for the order to be filled. The nurse remembered Resident #1 had been admitted on a weekend. She added the facility's pharmacy was not open on the weekend and the only medications available to newly admitted residents were the ones available in the facility's back up medication kit. The nurse stated Resident #1 requested pain medication. At that point, she had not had time to enter the resident's medications into the electronic system. When she finally entered the medications, and before the medications could be delivered, she had looked in the facility's emergency narcotic box and found the pain medication ordered for Resident #1 was not in the emergency kit. Nurse #2 added the resident's RP requested she call the physician to ask for a strength of pain medication available, but the resident declined. Nurse #2 added if the resident had been on routine medications not available from the emergency drug kit, she would have borrowed the medication needed from another resident, since she would not have received Resident #1's medications until Monday. Nurse #3 was interviewed on 5/6/16 at 7:53 AM. Per the facility's assignment sheet, he was the nurse on duty for the area that included Resident #1's room. He stated he remembered nothing about the day or the resident.</p> <p>A call was made to the hospital discharge planner on 5/6/16 at 9:15 AM and a message left. There was no return call.</p> <p>The Director of Nursing (DON) was interviewed on 5/6/16 at 3:06 PM. She described the admission process and added if a resident was admitted on the weekend, a back up pharmacy was available to deliver all needed medications. Additionally, the facility had an emergency kit of narcotics and routine medications that were</p>	F 425			

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	Continued From page 31 commonly used for residents. The DON stated the admission medications were taken from the discharge summary and entered into the electronic medical record. She reviewed the information for Resident #1 and stated with the vertebral fractures, patella fracture and the rib fractures, she would have expected Resident #1 to receive pain medication when she requested the pain medication. The DON reviewed the resident's discharge summary and stated the pain medication ordered for Resident #1 had been in the facility's emergency narcotic kit. A telephone interview was held Resident #1 on 5/6/16 at 3:43 PM. She stated she left the hospital at 2:00 PM so her arrival at the facility was approximately 2:15 PM. She stated the only nurse she saw after arriving at the facility was Nurse #2 who went in and introduced herself. The resident stated she first asked for a pain medication around 3:00 PM. Resident #1 stated Nurse #2 told her she had to key in her medications into the electronic system before she could get pain medication. The resident added the second time she asked for pain medication, Nurse #2 told her she still had not keyed in the medication, but since there was no on-site pharmacy, it would be Monday before her medications arrived. The resident stated it had been her decision to come to the facility for rehabilitation after her accident and hospitalization and it was her decision to leave the same day because she was not going to get her medication before Monday. The resident was unsure of when she left the facility, but stated she arrived home at 8:00 PM, but added the drive from the facility to her home was less than 30 minutes.	F 425			
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		5/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441 SS=D	Continued From page 32 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to change gloves between dirty and clean tasks for 1 of 4 residents (Residents # 10) reviewed for infection control practices. Findings included: 1. Nursing Assistant (NA) #3 was observed providing incontinent care for Resident #10 on 5/6/16 at 6:05 AM. The NA removed the resident ' s brief. Resident #3 ' s perineum was cleaned from front to back. When the NA turned the resident on her left side, she removed the bowel movement with disposable wipes. Without removing the gloves, the NA opened the resident ' s nightstand and removed a tube of barrier cream. She took the top off the barrier cream, applied the cream to the resident ' s buttocks, replaced the top of the tube and replaced the tube into the resident ' s nightstand. The NA continued care without moving the gloves to include applying a new brief and touching the resident ' s clean linens. NA #3 was interviewed on 5/6/16 at 6:55 AM. NA #3 stated she should have changed her gloves between dirty and clean tasks such as cleaning the bowel movement and touching the resident's furniture, tube of moisture barrier and clean clothing. She added that not changing gloves would increase the risk of germ transmission. The Director of Nursing was interviewed on 5/6/16 at 2:14 PM. She stated at the present time, she was also functioning as the Infection Control Nurse. She stated staff were taught to wash hands in orientation and during training on the floor. The DON stated she expected staff to wash their hands between residents, after	F 441	One to one inservicing with NA#3 occurred on 5/27/16. Inservicing included the proper steps in providing incontinent care to include when to change gloves during the procedure and appropriate hand hygiene. Inservice also included that failure to change gloves after performing a dirty task greatly increases the risk of spread of infections. Staff are to remove gloves immediately after performing a dirty task, perform hand hygiene, then apply clean gloves before performing a clean task. In-servicing by the staff development coordinator or designee began on 5/16/16 and will be completed by 5/26/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include the proper steps in providing incontinent care to include when to change gloves during the procedure and appropriate hand hygiene. Inservicing began on 5/27/16 and will be completed by 5/29/16 for current employees. Newly hired staff will be inserviced during new hire orientation and all other staff will receive the inservices prior to working their next shift. In-service will include that failure to change gloves after performing a dirty task greatly increases the risk of spread of infections. Staff are to remove gloves immediately		

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

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/06/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 34 incontinent care, when their hands were visibly dirty and between dirty and clean tasks. She stated NA #3 should have removed the gloves after cleaning the bowel movement and prior to touching clean items.	F 441	<p>after performing a dirty task, perform hand hygiene, then apply clean gloves before performing a clean task.</p> <p>Director of nursing, assistant director of nursing/100 and 300 nurse manager, 200 hall nurse manager, 400 and 500 nurse manager and staff development coordinator will monitor compliance by observing incontinent care on 2-3 staff members per shift weekly times four then monthly times two to ensure the process includes when to change gloves and appropriate hand hygiene when performing clean and dirty task.</p> <p>The director of nursing or designee will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		