

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

PRINTED: 12/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/17/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and family interview, the facility failed to ensure family notification for 1 of 1 residents transferred to the</p>	F 157	No further corrective action required for resident #154. Resident #154 did not return to the Brian Center of Wilson after	12/15/16	

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

TITLE

(X6) DATE

Electronically Signed

12/07/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1 hospital by a dialysis center (Resident # 154).</p> <p>Findings included:</p> <p>1. Resident # 154 was admitted to the facility on 8/30/16 with diagnosis of End Stage Renal Disease with hemodialysis three times weekly.</p> <p>A review of the 5-Day Minimum Data Set assessment dated 9/13/16 revealed Resident # 154 was able to understand others and communicate effectively. Resident # 154 was listed as his own Responsible Party with four family members listed as contacts.</p> <p>A review of the Progress Notes for 9/22/16 at 11:06 AM revealed Resident # 154 was "sent to hospital from dialysis after treatment." The entry was written by Nurse # 1. On 9/22/16 at 2:26 PM, Nurse # 1 documented Resident # 154 was "sent to hospital after dialysis, advised unresponsive, called (hospital) ER (Emergency Room) who advised res(resident) admitted d/t (due to) unstable vs (vital signs)."</p> <p>A review of the Progress Notes for 9/22/16 at 5:34 PM revealed Nurse # 2 documented "sent to (hospital) ER from dialysis for unresponsiveness and hypotension. " On 9/22/16 at 9:09 PM, Nurse # 2 documented, "Resident was admitted to (hospital) intensive care unit. Resident's (family member) called to inform this RN (Registered Nurse) that resident was in intensive care and on ventilator at this time and in critical condition. (Family member) states that he was not notified by dialysis center of (Resident # 154) being sent to hospital. " DON (Director of Nursing) notified of situation."</p>	F 157	<p>the date of alleged deficient practice.</p> <p>All residents with appointments, procedures outside of the Brian Center of Wilson have the potential to be affects by the alleged deficient practice. A 100% audit of all residents with outside appointments starting on 11-18-16 thru 12-6-16 will be conducted by the DON (Director of Nursing) to ensure, if resident did not return to the facility, was sent to the hospital from an outside entity or was directly admitted to the hospital that the appropriate family/ responsible party was notified. These audits will continue X 4 months and then random audits will be done monthly x 2 months. All licensed staff will be in-serviced by the Director of Nursing (DON) and/or designee on Notification of Change to include outside appointments/ procedures in which the resident does not return to the Brian Center of Wilson to ensure that the family/ responsible party has been notified.</p> <p>A new system will be put into place that will require the licensed nurse to notify the DON and/or On-Call nurse of any resident that is directly admitted to the hospital from an outside entity and if the family/ responsible party was notified.</p> <p>The results of the audits will be taken thru the QAPI process monthly x 4 months for follow up and further recommendations as needed.</p>		

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F 157	<p>Continued From page 2</p> <p>During an interview on 11/17/16 at 11:45 AM, Nurse # 1 stated she worked the 7-3 shift on 9/22/16. Nurse # 1 stated she did not call the family because the resident left the facility and was sent to the hospital from dialysis. Nurse # 1 stated if she had sent Resident # 154 out or if he left from the facility, she would be responsible to call to notify the family.</p> <p>During an interview on 11/17/16 at 11:26 am, Nurse # 2 stated she worked the 3-11 shift on 9/22/16. Nurse # 2 stated she did not call Resident # 154's family when she learned the resident was sent from dialysis to the hospital because dialysis notified the family when they sent a resident to the hospital. Nurse # 2 stated she did not know the details and would not be able to answer family questions. Nurse # 2 stated, "Dialysis always calls the family. At 3:00 PM, I assume care of my residents and am responsible for them. If I send a resident out, I call the family. When a resident leaves the facility for a consultation or other medical service, the resident is in the care of that facility and that facility is responsible for calling the family."</p> <p>During an interview on 11/17/16 at 11:09 AM, the Dialysis Nurse Clinical Director (NCD) stated dialysis staff notified residents' family if there was a change in status or if they were sent to the hospital because dialysis staff were responsible for the resident while the resident was in their care. The NCD stated she spoke to Resident # 154's (family member) and explained they took full responsibility for not notifying him. "It got crazy here and it was overlooked. Everyone thought everyone else had called."</p> <p>During an interview on 11/17/16 at 11:50 AM, the</p>	F 157			

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F 157	Continued From page 3 Director of Nursing (DON) stated the first they knew of Resident # 154's hospitalization was when the (family member) came telling them he was not notified of the resident being transferred to the hospital. The DON stated they do not call families if a resident is sent from dialysis to the hospital because they are not responsible for the resident after the resident leaves the facility and is under the care of another medical facility. During an interview on 11/17/16 at 2:05 PM, Resident # 154's Family Member stated the family was not notified by the nursing home, the dialysis center, or the hospital of the resident's hospitalization or that he was placed on a ventilator. He stated if (another family member) had not happened to visit the nursing home that evening, the family would not have known Resident # 154 was in the hospital. He stated the nursing home's administrative staff were not aware of the hospitalization until he told them. During an interview on 11/17/16 at 2:45 PM, the Administrator stated when the facility recently sent Resident # 154 to the ER for evaluation, the facility notified the family. However, when the dialysis center sent the resident to the hospital of 9/22/16, it was the responsibility of the dialysis center to notify the family of Resident # 154's hospitalization as the resident was under their care at the time of transfer to the hospital.	F 157			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		12/15/16	

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F 356	<p>Continued From page 4</p> <ul style="list-style-type: none"> o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post nurse staffing in an area in the facility where it would be visible to residents and visitors. Findings included:</p> <p>On 11/14/2016 at 9:30 AM during a tour of the facility, the nurse staffing for the facility was not posted. A second attempt was made to locate the staffing on 11/14/2016 at 2:30 PM.</p>	F 356	<p>No residents were directly affected by the alleged deficient practice.</p> <p>No other residents have the potential to be affected by the alleged deficient practice.</p> <p>The DON (Director of Nursing) and ADON (Assistant Director of Nursing) were in-serviced by the Administrator on</p>		

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F 356	Continued From page 5 In an interview on 11/15/2016 at 10:30 AM, the Director of Nursing (DON) stated either the Assistant Director of Nursing (ADON) or herself posted the staffing. The DON noted the ADON was busy and did not post the staffing. The DON stated her expectation was the staffing would be posted daily. On 11/17/2016 at 2:00 PM, in an interview, the Administrator stated his expectation was the staffing would be posted daily.	F 356	11-17-16 about the staff posting requirements per state regulation. The DON/ADON will print, every Wednesday, the staffing posting for the facility for the entire week (Thursday thru Wednesday) and ensure it is posted in a prominent place readily accessible to the residents and visitors (Across from the nursing station on a bulletin board- now labeled "Staffing"). The Administrator will conduct random audits throughout the day and week to ensure the staff posting is up and visible X 4 months. The results of these audits will be taken thru the QAPI process monthly x 4 months for follow up and further recommendations as needed	