STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		9/11/18

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

Electronically Signed | 08/31/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the comprehensive assessment for the resident ' s diagnosis for 1 of 24 sampled residents reviewed for assessments (Resident #60). Findings included: Resident #60 was admitted to the facility on 9/28/17 and the facility diagnoses were epilepsy, dementia without behavioral disturbance, fracture of ribs and nasal bones, anxiety, and generalized muscle weakness. The physician order dated 11/8/17 was for Buspirone HCL 5 mg three times a day (anti-anxiety medication).	F 636	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 636 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the	

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F 636	Continued From page 2 Resident #60 ' s quarterly Minimum Data Set (MDS) assessment dated 6/28/18 revealed the resident had adequate hearing, clear speech and was understood and understands. Her cognition was unable to be assessed secondary to memory deficit. The resident had no behaviors. The resident required extensive assistance of 2 staff for transfer and one staff for all other activities of daily living (ADL) except meals were set up. The active diagnoses were non-Alzheimer ' s dementia, seizure disorder, schizophrenia, and asthma. A review of Resident #60 ' s care plan dated 7/8/18 revealed goals and interventions for emotional and intellectual needs, ADL deficit, behavior and communication deficit, impaired cognition, psychotropic medication for anti-psychotic and anti-anxiety, seizure, and at risk for respiratory complications. On 8/9/18 at 11:30 am an interview was conducted with the MDS Nurse who stated that the resident was not coded for anxiety on the quarterly 6/28/18 MDS and should have been. The resident had the diagnoses and was receiving anxiety medication during the look-back period. On 8/9/18 at 3:45 pm an interview was conducted with the facility Director of Nursing who stated she expected the MDS to be coded accurately.	F 636	last fourteen days to verify accurate coding of Section I of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #60 had a modification of section I to reflect the appropriate diagnosis for Assessment Reference Date 6/28/18. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in MDS coding of sections I related to accurate coding of MDS according to the RAI Manual on September 4, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for 3 additional months to verify accurate coding of Section I of the MDS. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be	

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F 636	Continued From page 3	F 636	presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive assessment for the significant change of decline and ordered Hospice services for 1 of 2 sampled	F 637	Revision: Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of	9/11/18

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F 637	Continued From page 4 residents reviewed for significant change (Resident #37). Findings included: Resident #37 was admitted on 3/9/16 with the diagnoses psychotic disorder with delusions from unknown physiological condition, major depressive disorder, Chron ' s disorder, hypercalcemia, adjustment insomnia and anxiety, central pain syndrome, and Huntington ' s disease. A review of Resident #37 ' s quarterly Minimum Data Set (MDS) dated 5/26/18 revealed the resident had adequate hearing, unclear speech, and never understood or understands. The cognition was severely impaired and there was no psychosis or behaviors. The resident required extensive assistance of two staff for all transfers and one staff for all other activities of daily living (ADL). The active diagnoses were anemia, non-Alzheimer ' s dementia, Huntington ' s disease, anxiety, dysphagia, Chron ' s disease, and abnormal weight loss. Resident #37 ' s care plan dated 5/30/18 review revealed goals and interventions for dependent for emotional and intellectual needs, ADL deficit, physical behaviors, communication and cognitive deficit, high risk for falls, gastrointestinal deficit, anti-anxiety and anti-depressant medication, neurological deficit, and nutritional decline. Physician order dated 7/3/18 for hospice services and order dated 7/9/18 for oxygen 3 liters per nasal cannula for shortness of breath and hypoxia.	F 637	facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 637 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of all current residents who received Hospice Services in the last six months to ensure that a Significant Change in Status Assessment has been completed within 14 days following the change in status per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #37 had a Significant Change in Status Assessment completed with an Assessment Reference Date of 8/8/18 to reflect Hospice Services. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in selecting appropriate Assessment types and Assessment Reference Dates according to the RAI Manual on September 4, 2018. The	

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F 637	Continued From page 5 Physician order dated 7/3/18 for Morphine 5 milligrams sublingual every 2 hours as needed. A review of Resident #37 ' s care plan revealed it was updated on 7/3/18 to reflect Hospice services. There were no interventions for Hospice services documented and no goals or interventions found for significant change. On 8/7/18 at 10:30 an interview was conducted with NA #12 who stated she was sitting/supervising Resident #37 who had a decline in nutritional intake with weight loss and increased confusion from dementia making the resident a high risk for fall. NA #12 stated that the resident was placed on Hospice services in July. On 8/7/18 a review of Resident #37 ' s Minimum Data Set record since 7/1/18 revealed there was no significant change assessment completed. On 8/9/18 at 11:30 am an interview was conducted with the MDS Nurse who stated that Resident #37 did not have a significant change assessment, it was overlooked. The resident should have had an assessment within 14 days of the Hospice order dated 7/3/18. On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected an assessment to be completed according to regulation for significant change.	F 637	RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for 3 additional months to verify that resident's receiving Hospice Services have an appropriate Significant Change in Status Assessment completed within 14 days following the change in status per the Resident Assessment Instrument (RAI) Manual guidelines. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. Any resident converting to Hospice Services will be discussed by the Administrator in the Daily Morning Meeting, Monday thru Friday, with the Interdisciplinary Team to ensure that MDS has received knowledge of the Hospice conversion, thus allowing the MDS Team to schedule appropriate Assessment Reference dates to capture Hospice Services. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management	

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F 637	Continued From page 6	F 637	Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the active diagnoses for 2 of 31 residents (Resident #63 and Resident #10), the medications received for 1 of 31 residents (Resident #83), and the discharge status for 1 of 31 residents (Resident #124) reviewed for the accuracy of assessments. The findings included: 1) Resident #63 was admitted on 9/20/12 with re-entry to the facility from the hospital on 8/16/17. The resident ' s list of cumulative diagnoses included atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart disease), anemia in neoplastic disease (a condition that causes tumor growth), and acute on chronic systolic (congestive) heart failure. A review of Resident #63 ' s medical record included a provider progress note signed by his Nurse Practitioner on 5/9/18. The note indicated Resident #63 ' s problem list included: atrial	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 641 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last 14 days to verify accurate coding of Sections A, I and N of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #63	9/11/18

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F 641	Continued From page 7 fibrillation (onset 10/18/15 and noted as active, chronic); anemia (onset 10/18/15 and noted as active, chronic); and congestive heart failure (onset 10/18/15 and noted as active, chronic). A review of Resident #63 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 6/29/18 was completed. Section I of the MDS assessment did not include a diagnosis of atrial fibrillation, anemia, or heart failure. An interview was conducted on 8/9/18 at 11:30 AM with the facility ' s MDS Nurse. During the interview, the nurse was asked to review Section I of the 6/29/18 quarterly MDS assessment for Resident #63. Upon review of the MDS, the nurse confirmed atrial fibrillation, anemia, and heart failure were not checked as active diagnoses for this resident. When the resident ' s medical record was reviewed, the nurse also confirmed Resident #63 had an active diagnosis of atrial fibrillation and received Eliquis (an anticoagulant) as part of his treatment; he had an active diagnosis of anemia and received Niferex (an iron supplement) to treat it; and, the resident had an active diagnosis of heart failure and received bumetanide (a diuretic) as part of his treatment regimen. The nurse reported the resident was care planned for atrial fibrillation and heart failure. The MDS Nurse stated the MDS coding should match the diagnoses, medications, and care plan. The nurse reported she would have expected that, "I would have coded it." An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the missing diagnoses on the MDS assessments were discussed. When the DON was asked what	F 641	had modification of section I to reflect accurate medical diagnoses for Assessment Reference Date 6/29/18. Resident #10 had a modification of section I to reflect accurate coding of the medical diagnoses for Assessment Reference Date 5/11/18. Resident #83 had a modification of section N for Assessment Reference Date 7/7/18 to reflect the accurate coding of medications. Resident #124 had a modification of section A for Assessment Reference Date 6/16/18 to reflect the residents accurate discharge location. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in MDS coding of sections A, I and N related to accurate coding of MDS according to the RAI Manual on September 4, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for an additional 3 months to verify accurate coding of Sections A, I and N of the MDS. One to one education will beprovided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and	

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F 641	Continued From page 8 her expectations were for the MDS assessment, she stated she would expect the proper diagnoses to be identified for all medications given and coded accurately on the MDS. 2) Resident #10 was admitted on 1/4/18 with re-entries to the facility from the hospital on 5/3/18 and 5/17/18. His cumulative diagnoses included a seizure disorder. A review of Resident #10 ' s medical record included a provider progress note signed by his Nurse Practitioner on 4/4/18. The note indicated Resident #10 had a medical history which included seizure disorder and epilepsy. Further review of the resident ' s medical record included a 4/26/18 physician ' s progress note. The physician indicated in her notations Resident #10 had a history of traumatic brain injury with residual global deficits and seizure disorder. Seizures were reported to be controlled with levetiracetam (an anticonvulsant medication) given as 500 milligrams (mg) by mouth twice daily. A review of Resident #10 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 5/11/18 was completed. Section I of the MDS assessment did not include a diagnosis of "Seizure Disorder or Epilepsy." An interview was conducted on 8/9/18 at 11:30 AM with the facility ' s MDS Nurse. During the interview, the nurse was asked to review Section I of the 5/11/18 quarterly MDS assessment for Resident #10. Upon review of the MDS, the nurse confirmed "Seizure Disorder or Epilepsy" was not checked as an active diagnosis for this	F 641	that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

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F 641	Continued From page 9	F 641		

resident. When the resident ' s medical record was reviewed, the nurse also confirmed the resident had a medical history of a seizure disorder and received levetiracetam to treat it. The nurse stated she would have expected that, "I would have coded it."

An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, concerns regarding the missing diagnoses on the MDS assessments were discussed. When the DON was asked what her expectations were for the MDS assessment, she stated she would expect the proper diagnoses to be identified for all medications given and coded accurately on the MDS.

3) Resident #83 was admitted on 1/20/17 with cumulative diagnoses in part of Alzheimer dementia, Diabetes Mellitus, and hypertension.

Record review of the Minimum Data Set (MDS) dated 7/7/18 indicated that he received 7 days of 7 doses of antipsychotic, antianxiety, antidepressant, antihypnotic, anticoagulant, antibiotic, diuretic and opioid medications.

Review of the medication administration record (MAR) for the month of July 2017 revealed he had received 7 doses for 7 days of insulin and an antidepressant only.

On August 9, 2018 at 4:38 PM during an interview and record review with MDS Coordinator stated Resident # 83 ' s MDS was coded incorrectly. He received 7 doses of an antidepressant and insulin.

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F 641	Continued From page 10 4) Resident #124 was admitted to the facility on 6/13/18 with diagnoses included acute respiratory failure, congestive heart failure, diabetes mellitus, chronic kidney disease stage 2. Record review of the nurse ' s discharge progress note, dated 6/16/18, revealed Resident #124 was discharged to another nursing facility on 6/16/18, upon resident ' s request. All belongings were given to the resident ' s daughter who transported the resident to that facility. Record review of the Discharge MDS assessment, dated 6/16/18, revealed Resident #124 was discharged to acute hospital. Record review of Resident 124 ' s Discharge Summary, dated 6/15/18, revealed the resident had initiated the discharge and was going to another nursing facility. The document signed by physician. During an interview on 8/8/18 at 9:50 AM, MDS Nurse stated the resident had a planned discharged and was discharged to another facility on 6/16/18. The nurse stated the discharge MDS dated 6/16/18 for Resident # 124 was incorrectly coded as discharge to acute hospital. During an interview on 8/9/18 at 6:34 PM, the Director of Nursing stated it was her expectation the MDS nurses provide accurate coding and reflecting actual resident ' s status on the MDS.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		9/11/18

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(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 657	Continued From page 11 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the resident ' s care plan to reflect the significant change and discontinuance of an anti-depressant for 1 of 24 sampled residents reviewed for care plan (Resident #37). Findings included: Resident #37 was admitted on 3/9/16 with the diagnoses psychotic disorder with delusions from unknown physiological condition, major	F 657	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F657 1. The plan of correcting the specific deficiency. The plan should address the	

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F 657	Continued From page 12 depressive disorder, Chron ' s disorder, adjustment insomnia, and anxiety. A review of physician order revealed Lexapro 5 mg was discontinued on 8/30/17. A review of Resident #37 ' s quarterly Minimum Data Set (MDS) dated 5/26/18 revealed the resident had adequate hearing, unclear speech, and never understood or understands. The cognition was severely impaired and there were no psychosis or behaviors. The resident required extensive assistance of two staff for all transfers and one staff for all other activities of daily living (ADL). The active diagnoses were anemia, non-Alzheimer ' s dementia, Huntington ' s disease, anxiety, dysphagia, Chron ' s disease, abnormal weight loss, insomnia, and Vitamin B12 deficiency. Resident #37 ' s care plan dated 5/30/18 review revealed goals and interventions for dependent for emotional and intellectual needs, ADL deficit, physical behaviors, communication and cognitive deficit, high risk for falls, gastrointestinal deficit, anti-anxiety and anti-depressant medication, neurological deficit, and nutritional decline. Physician order dated 7/3/18 for hospice services and order dated 7/9/18 for oxygen 3 liters per nasal cannula for shortness of breath and hypoxia. Physician order dated 7/3/18 for Morphine 5 milligrams sublingual every 2 hours as needed. A review of Resident #37 ' s care plan revealed there was an update on 7/3/18 to reflect Hospice services began in July. No goals or interventions	F 657	process that lead to the deficiency. a) The care plan for Resident #37 was updated on August 28, 2018 by the Resident Care Management Director related to the significant change of status and discontinuance of anti-depressant therapy. All residents who have had anti-depressant medication discontinued will have their care plan audited by the Resident Care Management Director by August 31, 2018 to assure the care plan is reflective of the current status. All residents who have had a significant change in status assessment in the last 90 days will have their care plan audited and updated, as needed, by the Resident Care Management Director by August 31, 2018 to assure the care plan is reflective of the current status. It is alleged that the facility failed to update a comprehensive care plan for the discontinuance of antidepressant medication and with a significant change in status assessment. (Resident #37) The process that led to the deficiency is Resident #37 plan of care was not updated with change of medication and significant change of status. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to ensure residents have care plans that reflect the resident□s current status. Staff education provided by the Director of Nursing (DON) on August 30, 2018 to Resident Care Management Director and Minimum Data Set (MDS) Coordinator on policy and procedure	

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F 657	Continued From page 13 were documented. There was no goal or intervention for significant change or for the discontinuance of an anti-depressant documented. On 8/7/18 at 10:30 an interview was conducted with Nursing Assistant (NA) #12 who was sitting/supervising Resident #37 and stated the resident had a decline in nutritional intake with weight loss and increased confusion from dementia making the resident a high risk for fall. NA #12 stated that the resident was placed on Hospice services in July. On 8/7/18 a review of Resident #37 ' s Minimum Data Set since 7/1/18 revealed there was no significant change assessment completed to trigger a care plan update. On 8/9/18 at 11:30 am an interview was conducted with the MDS Nurse who stated that Resident #37 did not have a significant change assessment, it was overlooked. The resident should have had an assessment within 14 days of the Hospice order dated 7/3/18 and a corresponding change in care plan. The discontinuance of the anti-depressant was overlooked on the care plan. On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected the care plan to be updated with changes as needed.	F 657	regarding revising the resident□s care plan to reflect the significant change and the discontinuance of anti-depressant medication. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The Resident Care Management Director will perform a documented audit of residents care plans after medication changes are ordered and with a Significant Change Assessment for 4 weeks, and then 10 random care plans weekly X 8 to ensure that the facility care plans are revised, as needed, to reflect the resident□s status. b) The Resident Care Management Director will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		9/11/18

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F 684	Continued From page 14 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to obtain physician ' s order for isolation precaution for 1 of 2 residents reviewed for isolation precaution (Resident #58) and failed to appropriately label the tube feeding formula for 2 of 3 residents reviewed for tube feeding (Resident #25 and Resident #1). 1. Resident #58 admitted on 6/16/17. Review of the quarterly Minimum Data Set (MDS) assessment, dated 7/18/18, revealed his intact cognition. His diagnoses included Methicillin Resistant Staphylococcus Aureus (MRSA - infection) in his eyes. Review of Resident 58 ' s plan of care, dated 8/3/18, revealed that he received antibiotic therapy and contact isolation precaution, related to MRSA. The goal was to monitor/prevent discomfort or adverse side effects of antibiotic therapy. The interventions were to administer medications as ordered by physician and maintain isolation contact precaution. Review of July - August 2018 physician ' s orders for Resident #58 did not reveal the order for isolation precaution.	F 684	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F684 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) Resident #58 currently has a physician□s order for Isolation Precautions. All residents who currently have Isolation Precautions had their medical records audited by the Director of Nursing on August 31, 2018 to assure there is a physician□s order for the Isolation Precautions. Resident #25 and Resident #1 currently have their tube feeding formula appropriately labeled. It is alleged that the facility failed to obtain a physician□s order for Isolation Precautions (Resident #58) and that the facility failed to properly label tube feeding formula for Residents #25 and #1. The process that led to the deficiency is on	

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F 684	Continued From page 15 Record review of Resident 58 ' s hospital discharged notes, dated 7/23/18, revealed 7/18/18 laboratory data results, indicated resident ' s eye infection with MRSA. Record review of physician ' s notes for readmission of Resident 58 ' s, dated 7/24/18, revealed the resident came from hospital after the treatment of eye infection with MRSA and continued antibiotic treatment. Record review of the nurses ' notes, dated 7/26/2018, revealed that Resident #58 continued to receive isolations precaution and antibiotic treatment of MRSA. On 8/6/18 at 9:50 AM, during the observation/interview, Resident #58 was in the room with contact isolation precaution sign and personal protective equipment (PPE) mounted to the door. The resident indicated that he received isolation precaution due to his eye infection, and the staff used PPE in his room. On 8/8/18 at 1:35 PM, during an interview, Nurse #1 indicated that Resident #58 received contact isolation precaution for the eye infection with MRSA. The nurse could not provide the current, revised or initial physician ' s order for contact isolation precaution. On 8/8/18 at 1:45 PM, during an interview, the Assistant of Director of Nursing (ADON) indicated that Resident #58 came from the hospital with diagnoses of MRSA in his eyes. He received contact isolation precaution. The ADON could not provide the physician ' s order for isolation precaution.	F 684	Admission the admitting nurse placed the Contact precautions set up outside of Resident#58 door, but did not obtain a physician□s order for the precautions and Licensed Nurse initiated new bottles of tube feeding formula without properly labeling the bottles for Residents #25 and #1. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to ensure residents on Isolation Precautions have Physician□s orders for the precautions and when initiating new bottles of tube feeding formula licensed nurses should label the bottles. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that residents on Isolation Precautions are to have Physician□s orders for the precautions and when initiating new bottles of tube feeding formula licensed nurses should label the bottles. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The SDC will perform a documented audit of all residents on Isolation Precautions to validate Physician□s orders and observation audits of all tube feeding formula bottles to validate proper labeling of bottle weekly for 4 weeks, and then 10 random care plans weekly X 8. b) The SDC will report findings of audits	

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F 684	Continued From page 16 On 8/9/18 at 9:30 AM, during an interview, the Director of Nursing (DON) indicated her expectation the nurses should obtain the order from physician to start/end the isolation precaution. 2. Resident #25 admitted on 9/21/17. Review of the quarterly MDS assessment, dated 5/16/18, revealed severe impaired cognition. Her diagnoses included dysphagia, stroke and Alzheimer ' s disease. She received tube feeding. Review of Resident 25 ' s plan of care, dated 5/30/18, revealed the resident received tube feeding and nothing by mouth. The goal was to provide adequate nutrition via enteral nutrition regimen, with no side effects of tube feeding. The interventions were to elevate head of bed during feedings and at least one hour after feeding, to have dietitian to observe caloric intake and estimate needs quarterly and as needed. Review of physician ' s order for Resident #25 revealed the order for Jevity 1.5 Cal (nutritional formula) at the rate of 100 ml (milliliter) per hour, from 7 PM to 7 AM enteral feed for nutrition and remove per schedule. Nothing by mouth diet. Record review of the multiple nurses ' notes for July-August 2018 revealed that Resident #25 received enteral feedings every day and tolerated it well. On 8/7/18 at 8:10 AM, during the observation/interview, resident was in bed. The tube feeding system was connected to resident ' s gastric tube (surgically inserted tube to the stomach) via working infusion pump. It was 1 L (liter) bottle of Javity, 1.5 Cal, with 780 ml of	F 684	monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The SDC will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

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F 684	Continued From page 17	F 684		

nutrition formula inside, not labeled with resident ' s name, date or time.

On 8/7/18 at 10:10 AM, during an interview, the Nurse Unit Manager indicated that she was responsible for tube feeding administration for Resident #25 last night. On 8/6/18 at 7 PM, the nurse started new bottle of Javity, 1.5 Cal on the rate of 100 ml per hour. She could not recall if she labeled the bottle.

On 8/9/18 at 1:10 PM, during an interview, the DON indicated that she expected the nurses to sign the tube feeding formula with resident ' s name, date and time of infusion.

3. Resident # 1 was admitted to the facility on 3/9/07 with the last readmission on 7/27/18 with diagnoses which include cerebrovascular disease, quadriplegia, dysphagia and gastrostomy status (tube placement in the abdomen for feeding nutrition).

Review of the physician orders dated 7/27/18 revealed Glucerna 1.5 Cal (supplement used for diabetic residents) at 65 milliliters (ml)/ hour (hr.) continuously via percutaneous endoscopic gastrostomy tube.

Review of the comprehensive annual MDS assessment dated 4/17/18 revealed Resident #1 was assessed as cognitively impaired with adequate hearing and unclear speech.

Review of Resident # 1 ' s plan of care, dated 4/18/18, revealed the resident received tube feeding. The goals were to provide adequate nutrition via enteral nutrition regimen, with no side effects of tube feeding. The interventions were to

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F 684	Continued From page 18	F 684		

elevate head of bed during feedings, observe/ document/ report any signs of aspiration, check tube placement and gastric residuals per facility protocol, provide tube feeding formula/ water flushes as ordered.

During an observation on 8/6/18 at 10:45 AM, Resident #1 was observed lying in bed. The tube feeding (TF) system was connected to resident ' s gastric tube (surgically inserted tube to the stomach) via working infusion pump. An empty 1 L (liter) bottle of Glucerna 1.2 Cal nutrition formula that was hanging, was not labeled with resident ' s name, date or time. Observations also revealed a flush bag hanging that was not labeled with resident ' s name, date or time.

During an observation on 8/6/18 at 3:32 PM, Resident # 1 was observed lying in bed, the infusion pump working, and TF system connected to resident ' s gastric tube via the infusion pump. An approximately half-empty flush bag was hanging that was not labeled with resident ' s name, date or time.

During an interview on 8/8/18 at 10:00 AM, Nurse # 1 indicated Resident # 1 was on continuous TF, Glucerna 1.5 Cal at 65 ml/ hour and 175ml every 6 ml of flushes that was infused by the infusion pump. She stated she does not recall if the bottle was labeled by the previous nurse. She stated she checked on the resident ' s TF site, gastric residuals and offered flushes as ordered before medication during medication administration, and did not observe if the bottle was labelled.

During an interview on 8/8/18 at 1:45 PM, Unit Manager indicated she was unsure why the nurse had not labelled the formula bottle and flush bag

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F 684	Continued From page 19 on 8/6/18. She stated when a new TF formula bottle or new flush bag was started, the nurse should label it with resident ' s name , date and time of infusion. During an interview on 8/9/18 at 6:45 PM, the Director of Nursing stated it was her expectation that nurses sign the TF formula with resident ' s name, date and time of infusion. She further stated it was the responsibility of all nurses to administer the correct nutritional formula at the correct rate as ordered by the physician.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		9/11/18

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F 693	Continued From page 20 by: Based on observations, record review and staff interview, the facility failed to follow the physician ' s order tube feedings (TF) for 2 of 5 sampled residents reviewed for tube feeding (Resident #1 and Resident # 68). Findings included: 1. Resident # 1 was admitted to the facility on 3/9/07. Resident #1 ' s diagnoses included cerebrovascular disease, quadriplegia, dysphagia and gastrostomy status (tube placement in the abdomen for feeding nutrition). Review of the comprehensive annual Minimum Data Set (MDS) assessment dated 4/17/18 revealed Resident #1 was assessed as cognitively impaired with adequate hearing and unclear speech. Resident was also assessed as requiring extensive one person assist with activities of daily living (ADL). Resident# 1 was assessed as having no swallowing disorder and receiving tube feeding. Review of Resident #1 ' s plan of care, dated 4/18/18, revealed the resident received tube feeding. The goals were to provide adequate nutrition via enteral nutrition regimen, with no side effects of tube feeding. The interventions were to elevate head of bed during feedings, observe/ document/ report any signs of aspiration, check tube placement and gastric residuals per facility protocol, provide tube feeding formula/ water flushes as ordered. Resident # 1 was readmitted on 7/27/18.	F 693	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F693 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) Resident #1 and Resident #68 are currently receiving their tube feeding per physician□s order. It is alleged that the facility failed to administer Residents #1 and Resident #68 tube feeding per physician order. The process that led to the deficiency is Licensed Nurses did not administer the tube feeding per physician□s order for Residents #68 and #1. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to ensure residents who receive tube feeding formula receive it per the physician□s order and when initiating new bottles of tube feeding formula licensed nurses should label the bottles. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that residents receive tube feeding formula receive it per the physician□s order and when initiating new bottles of tube feeding formula licensed nurses should label the	

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F 693	Continued From page 21 Review of the hospital discharge summary dated 7/27/18 revealed Resident #1 ' s TF order at discharge was Glucerna 1.2 Cal at 65 milliliters per hour (ml/hr.) and free water flushes at 175 cubic centimeters (cc) every 6 hours. Orders were verified and signed by the physician on 7/27/18. Review of the physician orders dated 7/27/18 revealed Glucerna 1.5 Cal at 65 ml/hr. continuously via percutaneous endoscopic gastrostomy (PEG) tube. 175 ml water every 6 hours flushes. Review of nursing notes from 6/1/18 through 8/1/18 revealed resident was reviewed by interdisciplinary team (IDT) in standard of care related to weight loss. Notes indicated Resident #1 was tolerating TF and flushes well. Weight loss was attributed to frequent hospitalizations due to Urinary Tract infection and due to some issues of PEG tube draining around the stoma site. During an observation on 8/6/18 at 10:45 AM, Resident #1 was observed lying in bed and the infusion pump was not running. The tube feeding (TF) system was connected to resident ' s gastric tube (surgically inserted tube to the stomach) via working infusion pump. An empty 1 L (liter) bottle of Glucerna 1.2 calories per cc nutrition formula was hanging. It was not labeled with resident ' s name, date or time. Observations also revealed a flush bag hanging that was not labeled with resident ' s name, date or time. During an observation on 08/06/18 at 3:32 PM, Resident#1 was observed in bed and the infusion pump indicated 60 ml/ hour and 175 ml flush	F 693	bottles. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The SDC will perform a documented observation audit of all residents who receive tube feeding to validate tube feeding is being administered per physicians orders and all tube feeding formula bottles to validate proper labeling of bottle weekly for 4 weeks, and then 10 random observations weekly X 8. b) The SDC will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The SDC will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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F 693	Continued From page 22	F 693		

every 6 hrs. Observation of the TF formula revealed 1 Liter (L) Glucerna 1.2 Cal labeled "8/6/18 at 10 AM ". Approximately 800 ml of formula was remaining in the bottle. The flush bag was half empty and had no label or date and time on it.

During an observation on 08/07/18 at 8:17 AM Resident #1 was observed in bed. The infusion pump was not running. The tube feeding system was not connected to resident ' s gastric tube. Observation also revealed a 1 L bottle of Glucerna 1.2 Cal was placed on the side table.

During an observation on 08/07/18 at 10:10 AM, Resident # 1 was lying in bed, the infusion pump was not started, and tubing system was not connected to the resident. Observations also revealed the 1 L Glucerna 1.2 Cal formula bottle was placed at the foot of the bed.

During an observation on 8/7/18 at 11:20 AM, Resident #1 was observed lying in bed and TF had not been connected and the infusion pump was not started.

During an observation and interview on 8/7/18 at 2:45 PM, Resident #1 was observed in activity room in a Geri recliner chair, watching TV. No TF was observed. Interview with the activity director revealed resident does not receive TF during activities.

During an observation on 8/7/18 at 5:45 PM, Resident #1 was observed in bed. TF infusion pump indicated the formula infusion rate was 60 ml/ hr. Nutrition formula Glucerna 1.5 Cal was hung and labeled "8/7/18 at 17:00".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 693	Continued From page 23	F 693		

During an observation on 8/8/18 at 7:40 AM, Resident #1 was observed sleeping in bed. TF infusion pump indicated the formula infusion rate was 60 ml/ hr. Nutrition formula Glucerna 1.5 Cal was hung and labeled "8/8/18 at 6:00".

During an interview on 8/8/18 at 10:00 AM, Nurse # 1 (assigned to the resident) stated Resident # 1 was on Glucerna 1.5 Cal at 65 ml/hr. and received 175 ml of water flushes every 6 hours. Nurse # 1 stated the resident received a pleasure tray and tube feeding was stopped one hour before meals. Nurse was unable to find the physician ' s orders for stopping the TF one hour before meals. Nurse # 1 further stated the resident ' s TF rate should be set at 65 ml/hr.

Review of nutrition assessment dated 8/8/18 revealed Resident #1 with significant weight loss (7.6% in 30 days) due to hospital stay. The Dietitian, in her nutrition assessment, recommended changing the enteral order to Glucerna 1.5 Cal (supplement used for diabetic residents) at 80 ml/ hr. for 20 hrs. and increase water flushes to 150 cubic centimeters (cc) every 4hrs to allow for care.

During an interview on 8/8/18 at 1:30 PM, Dietitian stated Resident # 1 was on continuous feeds of Glucerna 1.5 Cal at 65 ml/ hour. She further stated she had reassessed the resident on 8/7/18 and had increased the rate to 85 ml/hour for 20 hours to accommodate time for resident ' s care. The Dietitian indicated the TF was stopped during care by nursing staff, hence the rate of TF was calculated for a shorter period of time i.e. 20 hours. to accommodate Resident # 1 ' s nutrition needs. She indicated she was unsure why feeding was stopped for a prolonged period

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 693	Continued From page 24	F 693		

and she expected nursing staff to follow the physician's orders for tube feeding.

During an interview on 8/8/18 at 1:45 PM, Unit manager stated Resident # 1 was on continuous feeding - Glucerna 1.5 Cal at 65 ml/ hour. She stated the nurses were responsible to replace TF formula when bottle was empty and set the rate per physician orders. She indicated there was no system in place to document when the bottle was hung. She stated nurses should label, date and time the bottle when new TF formula bottle was replaced. She indicated there was no system to monitor the actual amount formula administered each date and it was the responsibility of nurses on all shift to check the amount and replace the formula bottle as needed.

During an interview 08/09/18 at 11:29 AM, the Physician stated it was her expectation the nursing staff follow physician orders and if orders were not feasible to notify her so that the orders could be clarified.

On 08/09/18 at 6:34 PM during an interview, Director of Nursing (DON), stated it was her expectation nursing staff follow orders, date, time and label the TF formula and hang a new TF formula when empty. DON also stated, all nursing staff were responsible to make sure to provide TF as ordered with correct nutrition formula and pump rate.
2.

Resident #68 was admitted on 4/22/98 with the diagnoses of hypertension, quadriplegia, and total brain injury (TBI).

Resident #68 ' s quarterly Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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F 693	Continued From page 25	F 693		

dated 7/2/18 revealed the resident had adequate hearing, unclear speech, and was rarely understood or understands. The resident had a severely impaired cognition with no behaviors. The resident required extensive assistance of two staff members for all activities of daily living (ADL). The active diagnoses were aphasia, hemiplegia, TBI, contracture of the left hand, dysphagia, gastrostomy, and functional quadriplegia.

A review of Resident #68 ' s care plan dated 7/3/18 revealed an ADL deficit and total care required, communication deficit, dependent for his physical and social needs, impaired cognition, potential for fluid volume deficit, tube feeding, and at risk for nutritional deficit.

On 8/6/18 at 9:30 am an observation was done of Resident #68 who was lying in his bed with the head of the bed elevated. A tube feeding pump was present with a ¾ full bottle of Jevity nutritional supplement that was dated. The pump was on hold and not running.

A review of Resident #68 ' s physician order dated 8/3/18 revealed Jevity 1.5 per gastrostomy tube via pump at 72 cubic centimeters (ccs) per hour, run 6 am - 4 pm and 6 pm - 4 am, 1440 milliliters total.
On 8/6/18 at 12:45 pm an observation was done of Resident #68 and his tube feeding was running at 72 ccs per hour.

On 8/7/18 at 9:25 am an interview with Nurse #3 who stated she turned Resident #68 ' s tube feeding off on 8/6/18 during 9:00 am medication pass because she thought that was the order, which was an error. Nurse #3 read the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 693	Continued From page 26 order and stated that the tube feeding was to be infusing from 6 am to 4 pm at 72 ccs per hour. Nurse #3 stated she turned the tube feeding back on around noon when she realized her mistake. On 8/7/18 at 11:10 am an observation was done of Resident #68 and his tube feeding was running at 72 ccs per hour. On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected staff to follow the tube feeding physician order.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews, the facility failed to obtain a physician order for oxygen administration and failed to administer the correct oxygen liter flow for 3 of 5 sampled residents reviewed for respiratory (Residents #26, #60, and #68). Findings included: 1. Resident #26 was admitted on 4/28/18 and the	F 695	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F695 1. The plan of correcting the specific deficiency. The plan should address the	9/11/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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F 695	Continued From page 27 diagnoses were pulmonary nodule, tachycardia, syncope and collapse, sepsis, pneumonia, respiratory failure with hypoxia, anemia, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and chronic kidney disease (CKD) stage 3. A review of Resident #26 ' s discharge with return anticipated Minimum Data Set dated 7/1/18 revealed the resident was moderately cognitively impaired with memory deficit. The resident required extensive assistance for all activities of daily living (ADL) except meals were set up. The active diagnoses were anemia, CKD stage 3, and COPD. Resident #26 ' s care plan dated 8/6/18 revealed goals and interventions for cardiac complications, ADL deficit, wishes to return home, at risk for dehydration, anemia, pneumonia, psychotropic medication, and nutritional decline. A review of the nurses ' note dated 5/8/18 revealed Resident #26 was resting in bed with oxygen at 2 liters in progress. The oxygen saturation was 66-88%, temperature was 97.3, pulse was 88, respiratory rate was 16, and blood pressure was 83/51. Emergency services (911) were called to transport the resident to the hospital. Resident #26 returned to the facility on 5/12/18 and the diagnoses were CHF and pneumonia. A review of the nurses ' note dated 5/25/18 revealed the resident had oxygen via nasal cannula (flow rate was not provided). A review of the nurses ' note dated 7/1/18 revealed the resident was re-admitted to the	F 695	process that lead to the deficiency. a) Resident #26, Resident #60 and Resident #68 are currently receiving oxygen per physician□s order. It is alleged that the facility failed to obtain and administer Residents #26, Resident #60 and Resident #68 oxygen per physician order. The process that led to the deficiency is Licensed Nurses did not obtain and administer the oxygen per physician□s order for Residents #26, #60 and #68. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to ensure residents who receive oxygen have a physician□s order for the oxygen and receive it per the physician□s order. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that residents who receive oxygen have a physician□s order and receive it per the physician□s order. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The Assistant Director of Nursing (ADON) or the Director of Nursing (DON) will perform a documented observation audit of all residents who receive oxygen to validate physician□s order and to validate oxygen is being administered per the physician□s order weekly for 4 weeks, and then 10 random observations weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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F 695	Continued From page 28 facility and was alert but very confused, unable to care for self and required total nursing care. A thoracentesis (removal of fluid from around the lung by needle aspiration) was performed at the hospital today of the left lung with 1500 cubic centimeters removed. There was slight swelling to the back of the left lower lobe (lung). The resident was wobbly on her feet and had gotten short of breath very easily. On 8/6/18 at 1:30 am an observation was done of Resident #26 who was wearing a nasal cannula and her oxygen concentrator regulator was set to 2.5 liters. On 8/6/18 a review of Resident #26 ' s physician orders did not reveal an order for oxygen. On 8/7/18 at 10:30 am an observation was done of Resident #26 who was wearing a nasal cannula and her oxygen oxygen concentrator regulator was set to 2.5 liters. On 8/8/18 at 2:05 pm an observation of the resident and her oxygen via nasal cannula oxygen concentrator regulator was set to 3.5 liters. On 8/8/18 at 2:05 pm an interview was conducted with Resident #26 who stated that her oxygen was increased to 3 liters today and she is feeling better. On 8/8/18 at 5:00 pm an observation was conducted of Resident #26 ' s oxygen concentrator which revealed a flow rate of 3.5 liters. Physician order created on 8/8/18 and back dated to 7/20/18 revealed oxygen 2 liters by nasal	F 695	X 8. b) The ADON or DON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The DON will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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F 695	Continued From page 29	F 695		

cannula as needed for shortness of breath.

Resident #26 ' s vital sign log for oxygen saturation revealed documentation of oxygen administration daily from 4/28/18 to 8/8/18. The oxygen flow rate was not documented.

On 8/9/18 at 10:00 am an interview was conducted with Resident #26 who stated she increased the oxygen flow rate on the oxygen concentrator yesterday because she had increased shortness of breath. The resident was comfortable with 2 liters of oxygen today. The resident stated she had not notified the staff and would let the nurse know if she was short of breath.

On 8/9/18 at 10:00 am an observation of Resident #26 was done, and the oxygen concentrator was set to 2 liters nasal cannula. The resident was relaxed and not short of breath.

On 8/9/18 at 10:10 am an interview was conducted with Nurse #6 who stated that she was not aware that Resident #26 had changed her oxygen concentrator flow rate yesterday while she was on duty. Nurse #6 stated that she checked the oxygen concentrator for flow rate as part of her assessment and had not observed 3 liters oxygen flow for her shifts.

On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected staff to obtain an order for oxygen and monitor the oxygen flow rate and document.

2.

Resident #60 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 695	Continued From page 30	F 695		

9/28/17 and the facility diagnoses were epilepsy, dementia without behavioral disturbance, repeated falls, fracture of ribs and nasal bones, anxiety, asthma, and generalized muscle weakness.

A review of Resident #60 ' s quarterly Minimum Data Set (MDS) assessment dated 6/28/18 revealed the resident had adequate hearing, clear speech and was understood and understands. Her cognition was unable to be assessed secondary to memory deficit. The resident had no behaviors. The resident required extensive assistance of 2 staff for transfer and one staff for all other activities of daily living (ADL) except meals were set up. The active diagnoses were non-Alzheimer ' s dementia, seizure disorder, schizophrenia, and asthma. The resident was oxygen dependent.

A review of Resident #60 ' s care plan dated 7/8/18 revealed goals and interventions for emotional and intellectual needs, ADL deficit, behavior and communication deficit, impaired cognition, seizure disorder, and at risk for respiratory complications.

A review of Resident #60 ' s record of vital sign revealed oxygen saturation by pulse oximetry dated from 2/28/18 to the 8/8/18 was documented that the resident was administered oxygen almost every day and the oxygen liter flow was not documented.

On 8/6/18 at 9:40 am Resident #60 was observed to be sitting in her wheel chair with a nasal cannula present in her nares and an oxygen concentrator flowing at 3 liters. The resident was verbalizing to herself and was confused. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 695	Continued From page 31	F 695		

oxygen concentrator was on the opposite side of the bed and not within the resident ' s reach. The resident was no observed to be short of breath.

On 8/6/18 at 9:45 am Resident #60 ' s physician orders were reviewed and an order for oxygen administration could not be found.

On 8/7/18 at 11:30 am Resident #60 was observed to be sitting in her wheel chair with a nasal cannula in her nares and an oxygen concentrator flowing at 3.5 liters. Review of the resident ' s record revealed there was no order for oxygen or nurses ' notes for oxygen administration or the flow rate.

On 8/7/18 at 4:00 pm Resident #60 was observed to be sitting in her wheel chair with a nasal cannula in her nares and an oxygen concentrator flowing at 3.5 liters. A review of the resident ' s record revealed there was no order for oxygen or nurses ' notes for oxygen administration or the flow rate.

On 8/8/18 a physician order dated 8/8/18 revealed oxygen tubing change every Monday for infection control and for oxygen 2 liters via nasal cannula as needed for shortness of breath (clarification effective 9/28/17 date of admission).

On 8/8/18 at 11:30 am an interview was conducted with the Administrator who stated, while looking at the medication orders in Resident #60 ' s record, that an oxygen order for 2 liters nasal cannula was written by the physician on 8/8/18 and dated for an effective date of 9/28/17. The Administrator stated he was now aware that the oxygen order was not present prior to 8/8/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 695	Continued From page 32 3. Resident #68 was admitted on 4/22/98 with the diagnoses of hypertension, quadriplegia, and total brain injury (TBI). Resident #68 ' s quarterly Minimum Data Set dated 7/2/18 revealed the resident had adequate hearing, unclear speech, and was rarely understood or understands. The resident had a severely impaired cognition with no behaviors. The resident required extensive assistance of two staff members for all activities of ADLs. The active diagnoses were hypertension, pneumonia, aphasia, hemiplegia, TBI, contracture of left hand, dysphagia, and functional quadriplegia. A review of Resident #68 ' s care plan dated 7/3/18 revealed an ADL deficit and total care required, communication deficit, dependent for his physical and social needs, impaired cognition, potential for fluid volume deficit, pneumonia, and potential for pain. A review of the nurses ' notes dated back to 3/22/18 revealed the resident was admitted with oxygen 3 liters nasal cannula. Nurses ' notes through 6/25/18 documented periodically that the resident was on 3 liters nasal cannula. Nurses ' notes after 6/25/18 did not mention oxygen administration. On 8/6/18 at 9:30 am an observation was done of Resident #68 who was lying in his bed with 2.5 liters of oxygen by concentrator flowing via nasal cannula that was lying on the floor. A review of Resident #68 ' s physician orders on 8/6/18 revealed there was no oxygen order	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 695	Continued From page 33	F 695		

identified in the record.

On 8/6/18 at 12:45 pm an observation was done of Resident #68 who was lying in his bed with 2.5 liters of oxygen by concentrator flowing and he was wearing his nasal cannula.

On 8/7/18 at 11:10 am an observation was done of Resident #68 who was lying in his bed with 2.5 liters of oxygen by concentrator flowing and he was wearing his nasal cannula.

On 8/8/18 at 9:30 am an observation was done of Resident #68 who was lying in his bed with 2.5 liters of oxygen by concentrator flowing via nasal cannula.

On 8/8/18 at 2:00 pm an observation was done of Resident #68 who was lying in his bed with 2 liters of oxygen by concentrator flowing via nasal cannula.

On 8/7/18 a review of Resident #68 ' s vital sign oxygen saturation revealed the resident was receiving oxygen from 3/22/18 to 8/7/18 and the flow rate was not documented.

On 8/7/18 at 9:25 am an interview was conducted with Nurse #3 who stated Resident #68 was supposed to be on 2 liters nasal cannula and the oxygen concentrator was dialed to 2.5 liters. Nurse #3 stated she lowered the oxygen to 2 liters after viewing the regulator at horizontal, eye level. Nurse #3 stated Resident #68 had no physician order for oxygen, there was a facility standing order for oxygen.

On 8/7/18 at 9:45 am an interview was conducted with the Director of Nursing who stated there

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F 695	Continued From page 34 were no facility standing orders. All orders were written by the physician. On 8/8/18 a physician order was created for 2 liters of oxygen via nasal cannula and back dated effective 7/29/18. On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected staff to obtain an order for oxygen and monitor the oxygen flow rate and document.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		9/11/18

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F 755	Continued From page 35 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to identify unused controlled substance medications for disposition (the process of returning and/or destroying unused medications) after a resident was discharged with his return not anticipated for 1 of 1 resident newly re-admitted residents reviewed (Resident #45). The findings included: Resident #45 was previously admitted to the facility on 6/1/18 with a cumulative diagnoses which included a history of throat and neck cancer. A review of Resident #45 ' s medical record revealed his medications included the following, in part: 2 milligrams (mg) hydromorphone (an opioid pain reliever) to be given as one tablet by mouth every 4 hours for pain (ordered 6/21/18); and 0.5 mg lorazepam (an antianxiety medication) to be given by mouth two times a day for anxiety (ordered 6/21/18). The resident was discharged to the community on 7/13/18 with his return not anticipated. However, Resident #45 was re-admitted to the facility on 7/24/18 from the hospital after experiencing a fall at home resulting in a fracture of the dens (a	F 755	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F755 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) Resident #45 is receiving medication per physician order. Resident #45 was discharged from the center, return not anticipated and the resident□s narcotics were not returned to the pharmacy. It is alleged that the facility failed to identify controlled drugs for disposition after Resident #45 discharged from the facility. The process that led to the deficiency is Licensed Nurses did not return Resident #45 narcotics to the pharmacy when Resident #45 discharged home return not anticipated. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to identify controlled drugs for	

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F 755	Continued From page 36 projection of the second cervical vertebra in the neck). A review of Resident #45 ' s medical record revealed his medications upon re-admission to the facility included the following, in part: 2 milligrams (mg) hydromorphone (an opioid pain reliever) to be given as one tablet by mouth every 3 hours for pain (ordered 7/24/18); and 0.5 mg lorazepam (an antianxiety medication) to be given by mouth two times a day for anxiety (ordered 7/24/18). A review of the resident ' s Controlled Medication Utilization Record (a declining inventory log for controlled substance medications) was conducted. These records included: --30 tablets of 2 mg hydromorphone were dispensed on 7/8/18 by the pharmacy for Resident #45. The Controlled Medication Utilization Record revealed that on the date of the resident ' s discharge from the facility (7/13/18), 3 tablets of 2 mg hydromorphone were remaining in the inventory. The declining inventory log showed use of these same tablets were resumed for Resident #45 upon his readmission to the facility on 7/24/18. --30 tablets of 0.5 mg lorazepam were dispensed on 7/9/18 by the pharmacy for Resident #45. The Controlled Medication Utilization Record revealed that on the date of the resident ' s discharge from the facility (7/13/18), 24 tablets of 0.5 mg lorazepam were remaining in the inventory. The declining inventory log showed use of these same tablets were resumed for Resident #45 upon his readmission to the facility on 7/24/18. An interview was conducted 8/9/18 at 7:25 AM with the facility ' s Director of Nursing (DON).	F 755	disposition after discharged from the facility or discontinuance of controlled medication. Licensed Nurse education to staff and agency Licensed Nurses provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that controlled drugs are to be sent to the pharmacy for disposition after a resident is discharged from the facility or discontinuance of controlled medication. Controlled Medications will be sent to the pharmacy, as indicated, with discontinuance of medication or discharge of the resident return not anticipated within 72 hours by the Unit Coordinators, Unit Managers, Assistant Director of Nursing or Director of Nursing. b) During their classroom orientation, newly hired Licensed Nurse education to staff and agency Licensed Nurses will be provided to include controlled drugs are to be sent to the pharmacy for disposition after a resident is discharged from the facility or discontinuance of controlled medication. Controlled Medications will be sent to the pharmacy, as indicated, with discontinuance of medication or discharge of the resident return not anticipated within 72 hours by the Unit Coordinators, Unit Managers, Assistant Director of Nursing or Director of Nursing. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The Assistant Director of Nursing (ADON) or the Director of Nursing (DON)	

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F 755	Continued From page 37 During the interview, the DON was made aware of the concerns regarding Resident #45's controlled substance medications from a previous admission (with return not anticipate) having been held in the facility for 10 days after the resident was discharged with his return not anticipated. Upon inquiry, the DON was asked how long controlled substance medications were kept in the facility after a resident was discharged with a return not anticipated. The DON stated narcotics (controlled substance medications) were supposed to be returned to the pharmacy within 3 days of a resident's discharge. The DON stated, "We've had so much agency (temporary nursing staff) help." A telephone interview was conducted on 8/9/18 at 3:00 PM with the facility ' s consultant pharmacist. Upon inquiry, the pharmacist was asked what he would expect the facility to do with controlled substance medications remaining after a resident has been discharged with a return not anticipated. The pharmacist reported he recommended the facility send the controlled substance medications back to pharmacy for destruction, so the count could be verified and the medications destroyed. He reported the medications should be sent to the pharmacy, "the sooner the better...would like to get them out of the (medication) cart due to accountability." When the situation for Resident #45 ' s medications were discussed, the pharmacist stated, "That's a concern and a longer time frame than would want." A follow-up interview was conducted on 8/9/18 at 3:09 PM with the DON in the presence of the facility ' s Administrator. During the interview, the DON was asked if there was a facility policy	F 755	will perform a documented observation audit of all residents narcotics and narcotic sheets when residents are discharged from the facility return not anticipated or when the is a discontinuance of controlled medication weekly for 4 weeks, and then 10 random observations weekly X 8 to validate narcotics are returned to the pharmacy within 72 hours of discontinuance of medication or discharge of the resident return not anticipated. b) The ADON or DON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The DON will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

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F 755	Continued From page 38 which addressed a time frame by which controlled substance medications should be sent back to the pharmacy for disposition after a resident ' s discharge. The DON stated there was not a facility policy which addressed the issue, but the guideline she gave her staff was to return these medications to the pharmacy within 72 hours of a resident ' s discharge.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 medication opportunities, resulting in a medication error rate of 7.6% for 2 of 5 residents (Resident #17 and Resident #24) observed during medication pass. The findings included: 1) On 8/9/18 at 8:35 AM, Nurse #3 was observed as she prepared and administered medications to Resident #17. The administered medications included a combination medication containing 500 milligrams (mg) calcium with 200 Units (U) Vitamin D given as one tablet via gastrostomy tube. A review of Resident #17 ' s Physician Order	F 759	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F759 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) It is alleged that Licensed Nurses #3 on 8/9/18 while administering medications to Residents #17 and #24 respectively. The process that led to the deficiency is the Licensed Nurse□s non-compliance with physician□s orders for medication and time of administration. 2. The procedure for implementing the	9/11/18

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F 759	Continued From page 39 Summary Report included a current order for 500 mg calcium to be given as one tablet via gastrostomy tube one time a day. An interview was conducted on 8/9/18 at 10:45 AM with Nurse #3. Upon request, the nurse reviewed Resident #17 ' s Medication Administration Record (MAR) and the manufacturer ' s labeling on the stock bottle of the combination calcium/Vitamin D tablets given to the resident. The nurse confirmed the medication ordered and indicated by the MAR was not the same as the combination medication administered to Resident #17. Further review of the hall medication cart revealed the calcium supplement (in the dosage ordered by the physician) was not stored on the cart. The nurse reported she would either need to get the correct calcium supplement on the cart or call the resident ' s physician to see if another stock product carried by the facility would be an appropriate alternative. An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nursing staff to deliver the medications without errors and administer the medications according to the physician's orders. 2) On 8/9/18 at 8:57 AM, Nurse #7 was observed as she prepared and administered medications to Resident #24. The administered medications included 25 milligrams (mg) quetiapine given as one tablet by mouth. Resident #24 ' s room was entered for the med administration at 9:09 AM. Upon entering the room, an observation was made of the resident lying in her bed with her breakfast meal tray (already eaten) placed on her	F 759	acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to administer medications per physician□s orders. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that physician□s orders are to be followed when administering medications as well as the Rights of Medication Administration including the right resident at the right time with the right medication in the right dose using the right route. b) Newly hired Licensed Nurses and Medication Aides will be educated during their classroom orientation that physician□s orders are to be followed when administering medications as well as the Rights of Medication Administration including the right resident at the right time with the right medication in the right dose using the right route. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The Director of Nursing (DON), Assistant Director of Nursing, Unit Managers, Unit Coordinators and SDC will perform fifteen random documented observations of Licensed Nurses and Medication Aides during Medication Administration Pass weekly for 4 weeks to include monitoring of medications administered before meals as ordered, and then 10 random observations to include monitoring of medications	

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F 759	Continued From page 40 bedside tray table. The resident ' s meal ticket indicated she had consumed pureed sausage patty, cream gravy, a pureed waffle with syrup, and a House Shake (a high calorie, high protein nutritional supplement). A review of Resident #24 ' s Physician Order Summary Report included a current order 25 milligrams (mg) quetiapine to be given by mouth one time daily before breakfast. An interview was conducted 8/9/18 at 10:40 AM with Nurse #7. During the interview, inquiry was made in regards to the physician order for quetiapine to be given before the breakfast meal. The nurse confirmed the physician ' s order was to give the medication before breakfast, but indicated she was filling in for a nurse who had called out and had started medication pass later than it was usually started. An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nursing staff to deliver the medications without errors and administer the medications according to the physician's orders.	F 759	administered before meals as ordered weekly X 8 to validate compliance with physicians orders. b) The DON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes to assure compliance is sustained with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The DON will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		9/11/18

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F 761	Continued From page 41 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications stored in 3 of 5 medication carts (100/300 Hall med cart, lower 400 Hall med cart, upper 600 Hall med cart) and in 2 of 2 medication rooms (100/200/300/400 Hall med room and 600 Hall med room). The findings included: 1) An observation of the Upper 600 Hall medication cart was conducted on 8/7/18 at 8:58 AM. The observation revealed a brown plastic bag containing 15 - single dose vials of 5 milligram (mg) / 1 milliliter (ml) haloperidol (an antipsychotic medication) dispensed from the pharmacy on 11/2/17 was stored on the medication cart. The manufacturer ' s expiration date stamped on each of the medication vials was April 2018.	F 761	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F761 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) It is alleged that the facility failed to discard expired medication from 3 of 5 medication carts and 2 of 2 medication rooms. The process that led to the deficiency is Licensed Nurses did not review expiration dates on medications in the medication carts and medication rooms.	

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F 761	Continued From page 42 An interview was conducted on 8/7/18 at 9:05 AM with Nurse #7. During the interview, the vials of haloperidol were inspected. Nurse #7 confirmed the vials were expired. Nurse #7 stated, "I ' ll take it (the haloperidol) off and sent to the pharmacy." An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired. 2) An observation of the Upper 600 Hall medication cart was conducted on 8/7/18 at 8:58 AM. The observation revealed an opened stock bottle of 100-count, 5 milligrams (mg) Enteric Coated bisacodyl tablets (a laxative) was stored on the medication cart in a drawer with the other stock medications. The manufacturer ' s expiration date stamped on the bottle was May 2018. An interview was conducted on 8/7/18 at 9:00 AM with Medication Aide (Med Aide) #1. Med Aide #1 was the nursing staff member assigned to the Upper 600 Hall medication cart. During the interview, the stock bottle of bisacodyl tablets was inspected. Med Aide #1 confirmed the medication was expired. An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired.	F 761	2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to discard expired medication. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that expired medications are to be discarded and not stored in medication carts or medication rooms. b) During their classroom orientation, newly hired licensed nurses will be educated that expired medications are to be discarded and not stored in medication carts or medication rooms. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) Expired medication in each medication cart and medication room was discarded by the Unit Managers (UM), Assistant Director of Nursing (ADON) or the Director of Nursing (DON) per facility policy. b) The Unit Managers (UM), Assistant Director of Nursing (ADON) or the Director of Nursing (DON) will perform a documented observation audit of all medication carts and medication rooms weekly for 4 weeks to validate there are no expired medications in the medication carts or stored in the medication rooms, and then 10 random observations weekly X 8 to validate there are no expired medications in the medication carts or stored in the medication rooms. If expired	

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F 761	Continued From page 43 3) An observation of the Lower 400 Hall medication cart was conducted on 8/7/18 at 8:25 AM. The observation revealed an opened stock bottle of 325 milligrams (mg) Enteric Coated aspirin tablets (100 count) was stored on the medication cart in a drawer with the other stock medications. The manufacturer ' s expiration date stamped on the bottle was June 2018. An interview was conducted on 8/7/18 at 8:30 AM with Nurse #3. Nurse #3 was the hall nurse assigned to the Lower 400 Hall medication cart. During the interview, the stock bottle of aspirin was inspected. Nurse #3 confirmed the medication was expired and reported the stock bottle of aspirin would need to be discarded. An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired. 4) An observation of the 600 Hall medication room was conducted on 8/8/18 at 7:55 AM. The observation revealed one unopened stock bottle of 81 milligrams (mg) Enteric Coated aspirin tablets (containing 120 tablets) was stored on the cabinet shelf with other stock medications. The manufacturer ' s expiration date stamped on the bottle was January 2018. An interview was conducted on 8/8/18 at 7:58 AM with Nurse #8. During the interview, the stock bottle of aspirin was inspected. Nurse #8 stated, "We don ' t use those," referring to the stock bottles of medications stored in the 600 Hall	F 761	medications are noted, the responsible licensed nurse will be provided one to one education by the DON and ADON. c) The UM, ADON or DON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes to assure compliance is sustained ongoing with all follow up action determined by the QAPI team. 4. Title of person responsible for implementing the acceptable POC. a) The DON will be responsible for the implementation of the acceptable plan of correction. 5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a) September 11, 2018	

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	345265	A. BUILDING _____ B. WING _____	C 08/09/2018

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F 761	Continued From page 44	F 761		

medication room.

An interview was conducted on 8/8/18 at 4:13 PM with the 2nd shift nurse assigned to work on the 600 Hall. The nurse reported a few stock bottles of medications had been previously stored in the 600 Hall medication room, but they were removed earlier in the day. Up until this date (8/8/18), the nurse reported these stock meds had been available for use on the 600 Hall.

An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired.

5) An observation of the 100/300 Hall medication cart was conducted on 8/7/18 at 8:05 AM. The observation revealed an opened vial of Novolog insulin was stored on the medication cart. The insulin vial was labeled as having been dispensed from the pharmacy on 12/29/17 and was dated as opened on 5/24/18. An auxiliary label placed on the vial by the pharmacy indicated the insulin needed to be discarded 28 days after opening.

According to the product manufacturer, once punctured (in use), Novolog vials may be stored under refrigeration or at room temperature; use within 28 days.

An interview was conducted on 8/7/18 at 8:10 AM with Nurse #1. Nurse #1 was the hall nurse assigned to the 100/300 Hall medication cart. During the interview, the opened vial of insulin was inspected. Nurse #1 stated, "It needs to go."

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F 761	Continued From page 45	F 761		

An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired.

6) Accompanied by the corporate Registered Nurse (RN), an observation was conducted on 8/8/18 at 8:05 AM of the 100/200/300/400 Hall medication room. The observation revealed one opened bottle of 25 milligrams/milliliter vancomycin (an antibiotic) eye drops compounded and dispensed by the pharmacy on 7/23/18 was stored inside a vial in the medication room refrigerator. An expiration date of 8/6/18 was written on the bottle of eye drops; a pharmacy label placed on the outside of the vial indicated the expiration date of the eye drops was 7/30/18.

An interview was conducted on 8/8/18 at 8:07 AM with the corporate RN. During the interview, the RN confirmed the vial of eye drops was expired and needed to be removed from the medication room refrigerator.

An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired.

7) Accompanied by the corporate Registered Nurse (RN), an observation was conducted on 8/8/18 at 8:05 AM of the 100/200/300/400 Hall medication room. The observation revealed 4 unopened, multi-dose vials (MDV) of influenza

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F 761	Continued From page 46 vaccine stored in the medication room refrigerator had an expiration date of 6/30/18. One opened, multi-dose vial (MDV) of influenza vaccine also stored in the refrigerator had an expiration date of 6/30/18 and was dated as opened on 11/21/17. An interview was conducted on 8/8/18 at 8:07 AM with the corporate RN. During the interview, the RN confirmed the 5 vials of Afluria were expired and needed to be removed from the medication refrigerator. An interview was conducted on 8/9/18 at 3:09 PM with the facility ' s Director of Nursing (DON). During the interview, the DON reported her expectation was for the nurses to evaluate the medications to be sure they were properly dated and not expired.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/11/18

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F 880	Continued From page 47 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 48 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to perform hand hygiene after a nurse handled an intravenous bag and its tubing after use on a resident, and before she handled medications during medication pass for 1 of 3 observations conducted for infection control. Findings included: On 8/7/18 at 9:05 am an observation was conducted of Nurse #3 who carried a completed bag of intravenous medication and its tubing from Resident #101 in her hand, walked down the hall to the medication cart, and discarded the contents in the medication cart garbage bag. Nurse #3 touched her computer, used her key to unlock the cart, and obtained medication from the drawer and placed them in a medication cup without washing her hands. Nurse #3 used hand sanitizer before entering the resident ' s room to administer the medication. On 8/9/18 at 9:20 am an interview was conducted with Nurse #3 who stated she discarded Resident #101 ' s completed intravenous (IV) antibiotic medication bag and tubing into the medication cart garbage bag. Nurse #3 stated she did not remember not washing her hands after discarding the resident ' s medication bag and tubing before	F 880	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provision of the Federal & State Law. F880 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) It is alleged that Licensed Nurse #3 failed to wash her hands after handling an intravenous bag and its tubing after use on a resident, and before she handled medications. The process that led to the deficiency is the Licensed Nurse□s non-compliance with infection control related to hand washing did not wash her hands after handling an intravenous bag and its tubing after use on a resident, and before she handled medications. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) It is the policy of Brian Center of Yanceyville to perform hand washing when indicated by Infection Control	

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F 880	Continued From page 49 continuing on with medication pass. Nurse #3 stated she thought she had washed her hands after discarding the IV bag and tubing and usually washed her hands between residents. 8/9/18 at 9:45 am an interview was conducted with the Infection Control Nurse (ICN) who stated all staff received infection prevention and control training upon hire and annually. The ICN also stated that there is an infection prevention policy that staff was expected to follow. On 8/9/18 at 3:45 pm an interview was conducted with the facility ' s Director of Nursing who stated she expected staff to follow the facility ' s infection control standards.	F 880	Practices. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that hand washing should be performed when hands are potentially contaminated from discontinuing intravascular lines and bags or handling intravascular lines or bags. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The SDC will perform a documented hand washing observation audit of Licensed Nurses during Medication Administration Pass weekly for 4 weeks, and then 10 random observations weekly X 8 to validate compliance with Infection Control Practices. The SDC will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI team. 4. Title of person for implementing the POC. a) The DON will be responsible for the implementation of the acceptable plan of correction. 5. Dates when the corrective action will be completed. The corrective action dates must be acceptable to the State. a. September 11, 2018	