STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	09/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 641 SS=D	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 observation, record review, and staff interviews facility failed to accurately code on a quarterly assessment the presence of a wander alarm and failed to accurately code tube feeding for 2 of 16 resident Minimum Data Set (MDS) assessments reviewed (Residents #31 and Resident #8). Findings included: 1. Resident # 31 was admitted to the facility on 3/12/16. Her diagnoses included dementia, congestive heart failure and hypertension. Review of a physician's order, dated 4/23/18 ordered the use of a wander alarm. Review of the resident's MDS assessment dated 8/20/18, coded as a quarterly assessment, specified no wander alarms were used during the look back period. Review of the August 2018 Treatment Administration Record revealed the battery on the wander alarm was checked nightly for function and placement. An observation conducted on 9/24/18 at 10:24 AM noted a wander alarm on Resident #31's right wrist. During an interview on 9/25/18 at 4:18 PM MDS Nurse #1 stated the assessment conducted 8/20/18 should have reflected the use of a wander alarm. He stated he would correct the assessment immediately. During an interview on 9/25/18 at 4:29 PM the Director of Nursing stated it was her expectation that MDS assessments are completed accurately.	F 641	F 641 Accuracy of MDS: Tube Feeding Resident #8 tube feeding was not coded on Section K0510b and K0710 on the MDS with ARD of 7/7/18 MDS. Resident #31 Wander alarm was not coded on Section PO200E on the MDS with ARD 8/20/19. A modification was completed on Resident #8 MDS with ARD 7/7/18 on 9/25/18 by the Director of Care management. A modification was completed on Resident # 31 MDS with ARD 8/20/18 on 9/25/18 by the Director of Care management. The District Director of Care Management and District Director of Clinical Services completed education to the Nursing home Administrator (NHA) , DON, Resident Care management Director(RCMD) , MDS nurse and Dietary Manager on coding Section K0510b and K 0710 of the MDS on 10/3/18. The District Director of Care Management and District Director of Clinical Services provided education to the NHA, DON, RCMD and MDS nurse on coding on Section P200E regarding wander alarms	10/22/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/16/2018

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F 641	Continued From page 1 2. Resident #8 was admitted to the facility on 12/29/15. His active diagnoses included quadriplegia, tracheostomy, and gastrostomy. Review of Resident #8's orders revealed he was ordered on 8/17/16 to receive nothing by mouth. He was also ordered on 12/1/17 to receive a bolus feeding five times a day for dysphagia which was discontinued on 9/4/18. Review of Resident #8's care plan dated 7/6/18 revealed he was care planned for potential nutritional problems related to being on tube feedings. The interventions included to provide his diet as ordered. Review of Resident #8's quarterly minimum data set assessment dated 7/7/18 revealed the resident was assessed in questions K0510 and K0710 to not receive nutrition via a feeding tube. During an interview on 9/25/18 at 12:04 PM Nurse #1 stated Resident #8 currently had a feeding tube in place. She further stated Resident #3 had always had a feeding tube since she began work in the facility two years ago. The nurse stated during her entire time working in the facility he always received his nutrition via his feeding tube. She further stated the resident was currently ordered to received nothing by mouth. During an interview on 9/25/18 at 3:47 PM the Dietary Manager stated she started working in June 2018 and Resident #8 had always had a feeding tube and was receiving his nutrition via	F 641	on the MDS on 10/3/18. Current residents with a tube feeding were audited to ensure their most recent OBRA MDS K0510b and K0710 tube feeding was coded accurately. District Director of Care Management conducted audit of current residents with feeding tube on 10/1/18 to ensure KO510b and K0710 was accurately coded. No further exceptions noted. Current residents with a wander alarm were audited to be audited to ensure wander alarms were accurately coded for P0200e within the last 90days. District Director of Care Management conducted the audit on current residents with wander alarms to ensure accuracy of coding P0200e on 10/1/18. Assessments with inaccuracies were completed and transmitted by 10/3/18. The Director of Nursing will audit the MDS for any resident that is completed that has a tube feeding weekly times four weeks to ensure accuracy of coding , and then monthly x 2 months. The findings will be reviewed at QAPI for 3 months. The Director of Nursing will audit the MDS for any resident that is completed that has a wander alarm weekly times four weeks to ensure accuracy of coding , and then monthly x 2 months. The findings will be reviewed at QAPI for 3 months. The DON and ADON are responsible for	

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F 641	Continued From page 2 his feeding tube in July. She further stated the MDS dated 7/7/18 was incorrect. During an interview on 9/25/18 at 4:02 PM MDS Nurse #1 stated the Dietary Manager completed section K of the MDS. He further stated after section K is completed he validated completeness of the MDS. After reviewing questions K0510 and K0710 on the 7/7/18 MDS assessment for Resident #8 he concluded the answers were inaccurate and he would modify them as soon as possible. During an interview on 9/25/18 at 4:06 PM the Director of Nursing stated it was her expectation that section K of the MDS accurately reflect the feeding tube status of the residents. She further stated Resident #8 received nutrition via his feeding tube and the MDS dated 7/7/18 was incorrect.	F 641	implementing the Plan of Corrections by 10/22/18.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		10/22/18

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F 690	Continued From page 3 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to keep a urinary catheter bag from coming in contact with the floor for 1 of 2 residents reviewed for catheter care. (Resident #8) Findings included: Resident #8 was admitted to the facility on 12/29/15. His active diagnoses included quadriplegia, tracheostomy, and gastrostomy. Review of Resident #8 ' s progress note dated 5/30/18 revealed the resident was placed on antibiotic treatment for a urinary tract infection. Review of Resident #8 ' s most recent minimum data set assessment dated 7/7/18 revealed the	F 690	F 690 Bowel-Bladder Incontinence, Catheter, UTI Resident #8 Foley catheter bag was noted on the floor on 9/27/18 by the surveyor. Once it was brought to the attention of the facility, the bag was correctly positioned on 9/27/18 by Nurse Aide # 1. It is unknown how the catheter bag got on the floor. The Director of nursing did a bedside visit to current residents with a Foley catheter on 9/27/18 to ensure the catheter was positioned appropriately. Current licensed nurses and Nursing assistants were provided education by the	

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F 690	Continued From page 4 resident was assessed as severely cognitively impaired. Resident #8 required extensive assistance with bed mobility, dressing, and toilet use. He was totally dependent on staff for eating and personal hygiene. Review of Resident #8's care plan dated 7/6/18 revealed the resident was care planed for having a urinary catheter. The interventions included catheter care per protocol. During observation on 9/27/18 at 8:33 AM Resident #8 was resting in bed with his eyes closed. His urinary catheter bag was observed to be lying flat on the floor next to his bed. It was not attached to the bed in any way. During observation on 9/27/18 at 8:36 AM Nurse Aide #1 knocked on the door and observed the resident from the door entrance. The catheter bag was visible on the floor from the door entrance. The Nurse Aide did not adjust the catheter bag and went to the next room continuing her rounds. During an interview on 9/27/18 at 8:38 AM Nurse Aide #1 stated catheter bags should not be in contact with the floor due to infection concerns. Upon observing Resident #8 again she stated his urinary catheter bag should never be on the floor. She concluded she did not notice the catheter bag was on the floor during her rounds. During an interview on 9/27/18 at 8:40 AM the Director of Nursing stated catheter bags should never come in contact with the floor because of infection risks. She further stated it was her expectation Resident #8 ' s catheter bag not touch the floor or be laying on the floor.	F 690	Assistant Director of Nursing or Director of Nursing on properly positioning of a Foley catheter. This education was completed by 10/22/18. The Director of Nursing or Assistant Director of Nursing will audit each resident with a Foley catheter 3 x weekly for 4 weeks to validate correct positioning of the Foley catheter bag, and then twice a month for two months. The findings will be reviewed at QAPI x 3 months. The DON and the ADON are responsible for implementing the Plan of Correction by 10/22/18.	

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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, record review, and staff interviews the facility failed to maintain a medication administration error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities resulting in a medication administration error rate of 7.4% for 1 of 3 residents (Resident #29) observed during medication pass. Findings included: Resident #29 was admitted to the facility on 9/8/18. Her active diagnoses included hypertension and cerebral infarction. Review of Resident #29's active orders for September 2018 revealed she was ordered Colace capsule 100 milligrams by mouth two times a day. Resident #29 was also ordered Midodrine HCl 10 milligrams by mouth three times a day. Review of Resident #29 ' s September 2018 Medication Administration Record revealed the resident was to receive the 100 milligrams of Colace and 10 milligrams of Midodrine at 9:00 AM each day. During medication pass observation on 9/26/18 at 8:33 AM, Nurse #2 was observed to give 5	F 759	F 759 D Free of medication error When administering resident #29 medications, Nurse #2 indicated she had completed the medication pass, but the surveyor alerted her that she had not given the Colace at all and only 5 mg of Midodrine. When the nurse was notified of this, she administered the Colace and Midodrine as ordered which was still in the acceptable time frame. This nurse was removed from the medication cart on 9/26/18. This nurse is not a current employee of the facility. The Director of Nursing, Assistant Director of Nursing and /or Unit manager will provide current licensed nurses education regarding ensuring the residents receive medications per MD orders. This education will be completed by 10/22/18. Medication Administration education will continue to be part of orientation protocol for new employees. The Director of Nursing, Assistant	10/22/18

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F 759	Continued From page 6 milligrams of Midodrine HCl to Resident #29. Nurse #2 did not give Colace 100 milligrams to Resident #29. During an interview on 9/26/18 at 8:47 AM Nurse #2 stated she had completed Resident #29 ' s medication pass for that morning. After review of Resident #29 ' s orders the nurse stated she only gave 5 milligrams of Midodrine and should have given 10 milligrams and she did not give Resident #29 her Colace 100 milligrams and she should have. The nurse provided the missed medications to Resident #29. During an interview on 9/26/18 at 9:23 AM the Director of Nursing stated it was her expectation to have a medication error rate of less than five percent. She further stated it was her expectation medications be given to the residents accurately and Nurse #2 had provided inaccurate medications to Resident #29 which resulted in two medication errors.	F 759	Director of Nursing and/or Unit manager will do random medication pass observations 2 x weekly for 4 weeks to ensure nurses provide resident with their medications per MD orders. The audits will then be conducted randomly monthly for 2 months. The results of the findings will be reviewed at QAPI x 3months. The DON and ADON are responsible for implementing the Plan of Correction by 10/22/18.	