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	345317	A. BUILDING _____ B. WING _____	C 11/09/2018

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BRIAN CENTER HLTH & RETIREMENT	**204 DAIRY ROAD CLAYTON, NC 27520**

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F 000	INITIAL COMMENTS The surveyor entered the facility on 10/30/18 to conduct a complaint investigation and exited on 10/31/18. Additional information was obtained on 11/5/18 and 11/9/18. Therefore, the exit date was changed to 11/9/18.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		11/21/18

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

Electronically Signed | 11/19/2018

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F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with the facility staff, radiology representative, and physician, the facility failed to promptly notify the physician of the radiology results from an x-ray performed on 1 of 3 residents reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on 9/5/18. Her cumulative diagnoses included end-stage kidney disease requiring hemodialysis, Type 2 diabetes, and coronary artery disease with a recent history of coronary artery bypass grafting (CABG) of two blood vessels. A review of Resident #1 ' s admission Minimum Data Set (MDS) assessment dated 9/12/18 revealed the resident had intact cognitive skills for	F 580	Resident #1 was discharged from the facility on October 22nd 2018. Current residents have the potential to be affected by the same alleged deficient practice. Radiology reports from 10/14/18 thru 11/14/18 of current residents were reviewed by the Director of Nursing on 11/19/18 to ensure there were no radiology reports the physician was not aware of or not notified timely. No negative findings were noted. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: November 1st 2018 the Assistant Director of Nursing started educating the licensed	

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F 580	Continued From page 2 daily decision making. Resident #1 required extensive assistance with bed mobility, transfers, dressing, eating, and personal hygiene; she was assessed to be totally dependent on staff for toileting and locomotion off the unit. A review of the resident ' s physician orders included the following medications, in part: 100 mg docusate (a stool softener) to be given as one tablet by mouth two times a day for bowel management, hold for diarrhea (initiated on 9/12/18). Review of a grievance report (dated 10/19/18) authored by the facility ' s Director of Nursing (DON) was conducted. This report was filed on behalf of Resident #1 and indicated the left side of the resident ' s stomach hit the bed rail when she was turned in bed for patient care on 3rd shift during early morning hours of 10/19/18. The resident went to an outside physician consultation on 10/19/18. After returning to the facility, Resident #1 reportedly complained of pain. The report stated, "Nurse notified MD (Medical Doctor) of pain and abdominal x-ray was ordered and completed." A review of Resident #1 ' s medical record included a Radiology Report of a 1-view abdominal x-ray obtained on 10/19/18. The results were electronically signed by the radiologist on 10/19/18 at 7:28 PM. The one-page written report included the word "alert" written in capital letters diagonally across the page. It read: "Results: There is mild colonic dilatation consistent with ileus (a medical term for the lack of movement somewhere in the intestines that may lead to a buildup and potential blockage of	F 580	nurses on timely notification of radiology reports to the physicians. The education was completed on November 15th 2018. Newly hired licensed nurses will receive this education by the Director of Nursing/designee during the orientation process. On November 1st 2018 the Director of Nursing and the Assistant Director of Nursing implemented taking the radiology reports to the clinical start up meeting. The results will be reviewed to ensure there is documentation by the licensed nurse that the physician was notified of the results. The clinical start-up meeting occurs Monday thru Friday. The review of radiology reports will be completed on the weekend by the Registered Nurse on call. This process will ensure daily monitoring. This monitoring will be on-going. Negative findings will be addressed when noted. The results of the clinical start up and weekend monitoring of the radiology reports and timely notification of the physician will be reviewed by the Interdisciplinary Team weekly times 4 weeks, biweekly times 2 and monthly times 3. Additional interventions will be implemented by the Interdisciplinary Team if deemed necessary. The results of the weekly, biweekly and monthly audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months to determine the effectiveness of this plan. The Quality Assurance	

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F 580	Continued From page 3 food material). The small bowel loops are unremarkable. There is no soft tissue mass or significant pathologic calcification. There is a moderate amount of colonic and rectal stool. Conclusion: Mild colonic ileus Moderate amount of colonic and rectal stool." An undated handwritten notation on the Radiology Report read, "Called to MD; Hold Colace (docusate); check for C.diff." C. diff is an abbreviation for Clostridium difficile, a bacteria that may cause diarrhea and potentially more serious intestinal conditions. A review of Resident #1 ' s medical record included a Nursing Note dated 10/21/18 at 10:18 PM. The note indicated the resident ' s family member was called and a request was made to transfer Resident #1 to the hospital. The resident ' s physician was contacted and the resident was transferred to the hospital at 8:00 PM on 10/21/18. An interview was conducted on 10/31/18 at 3:20 PM with a representative from the facility ' s contracted radiology service. Upon inquiry, the representative reported the word "alert" written in capital letters diagonally across the radiology report meant, "What you are looking for is positive on the diagnosis." The radiology representative also stated this report was auto-faxed to the facility (via a hard copy paper fax) on 10/19/18 at 7:32 PM. The radiology representative provided the fax number the report was sent to. During an interview conducted on 10/31/18 at 3:40 PM with the facility ' s Administrator and Assistant Director of Nursing (ADON), the facility ' s backup fax machine was identified as the fax	F 580	Performance Improvement committee will monitor for any negative patterns/trends. Additional interventions will be developed and implemented as needed to sustain substantial compliance. The Administrator is responsible for implementation of this plan of correction.	

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F 580	Continued From page 4	F 580		

number used by the radiology service to send Resident #1 ' s Radiology Report to the facility on 10/19/18.

An interview was conducted on 10/30/18 at 4:09 PM with Nurse #1. Nurse #1 was the 2nd shift nurse who was assigned to care for Resident #1 on 10/19/18, 10/20/18 and 10/21/18. Nurse #1 was also the nurse who sent the resident out to the hospital on 10/21/18. Upon inquiry, the nurse confirmed the handwritten notations on the 10/19/18 Radiology Report were made by her on 10/21/18. During a follow-up interview conducted on 10/31/18 at 4:00 PM, Nurse #1 reported she was unsure of the exact time when the Radiology Report was received. The nurse stated the report was found on the facility ' s backup fax machine on 10/21/18 during 2nd shift (3:00 PM - 11:00 PM).

A telephone interview was conducted on 10/31/18 at 12:21 PM with the facility ' s Medical Director (and physician for Resident #1). During the interview, the physician stated if there was an alert noted on the radiology report, he should have been notified of the results of the resident ' s x-ray, "sooner than 2 days." When asked, the physician indicated he may not have done anything differently if he had been notified of the radiology results sooner than he was (on 10/21/18). However, he stated he would have liked to have asked the nurse some patient assessment questions when the radiology report became available. He reported, "Ileus can mean a lot of things." The physician indicated that based on his understanding of the resident ' s condition on 10/19/18 and 10/20/18, he likely would have made the same treatment decisions as he had made on 10/21/18 (to discontinue the

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F 580	Continued From page 5 docusate and to test for C. diff.). An interview was conducted on 10/31/18 at 4:40 PM with the facility ' s Administrator and Assistant Director of Nursing (ADON). During the interview, the Administrator and ADON were asked what their expectations were in regards to notifying the physician of Resident #1 ' s radiology report. They reported that if the radiology service did not call with a critical result and the facility did not yet have the radiology report, it would be expected for the nurse to obtain radiology results within 24 hours.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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 staff and physician interviews, and record views from the facility and cardiac surgeon ' s office, the facility failed to accurately initiate new physician ' s orders based on recommendations made by a consulting provider for the treatment of a surgical wound and, failed to provide treatments for a surgical wound in accordance with the physician ' s orders for 1 of 1 resident (Resident #1) reviewed with a surgical wound.	F 684	Resident #1 was discharged from the facility on October 22nd 2018. Current residents have the potential to be affected by the same alleged deficient practice. Physician consults from 10/14/18 thru 11/14/18 of current residents were reviewed by the Director of Nursing on 11/19/18 to ensure new physician orders	11/21/18

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F 684	Continued From page 6 The findings included: Resident #1 was admitted to the facility on 9/5/18. Her cumulative diagnoses included end-stage kidney disease requiring hemodialysis, Type 2 diabetes, and coronary artery disease with a recent history of coronary artery bypass grafting (CABG) of two blood vessels. A review of Resident #1 ' s admission Minimum Data Set (MDS) assessment dated 9/12/18 revealed the resident had intact cognitive skills for daily decision making. Resident #1 required extensive assistance with bed mobility, transfers, dressing, eating, and personal hygiene; she was assessed to be totally dependent on staff for toileting and locomotion off the unit. Section M of the MDS assessment revealed Resident #1 was admitted with surgical wounds and received surgical wound care at the facility. A review of the resident ' s care plan included the following areas of focus, in part: --(Initiated on 9/6/18): [Resident ' s name] has actual impairment to skin integrity of the left leg and sternum related to being status post CABG. A review of Resident #1 ' s medical record included a Weekly Non-Pressure Condition Record dated 9/7/18. The resident was noted to have been admitted with a surgical incision midline chest measured as 18.5 centimeters (cm) in length. The edges of the surgical incision were described as " ...well approximated with 17 staples and 17 steri strips. No drainage noted, slight redness around the edges." Further review of the resident ' s medical record included a Progress Record dated 9/12/18 from	F 684	were transcribed correctly. The medication administration record and the treatment administration records from 10/14/18 thru 11/14/18 were also reviewed by the Director of Nursing at this time to identify any missing documentation. Negative findings were addressed when/if noted. Systemic measures implemented to ensure the same alleged deficient practice does not recur include: November 1st 2018 the Assistant Director of Nursing started educating the licensed nurses regarding physician consults and accurate transcription of physician orders. The Assistant Director of Nursing also educated licensed nurses regarding completion of documentation at this time. The education was completed on November 15th 2018. Newly hired licensed nurses will receive this education by the Director of Nursing/designee during the orientation process. On November 1st 2018 the Director of Nursing and the Assistant Director of Nursing implemented taking the physician consults to the clinical start up meeting for review to ensure the consulting physician orders are transcribed correctly. During the clinical meeting documentation on the medication/treatment records will be reviewed for missed entries. The clinical start-up meeting occurs Monday thru Friday. This review will be completed on the weekend by the Registered Nurse on	

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F 684	Continued From page 7 an outside consultation with her cardiac surgeon ' s office. This record reported the resident was not progressing as desired. Written recommendations made from the surgeon ' s office included applying wet to dry dressings three times a day at the distal end of the sternal incision. Notes indicated the resident was to be seen for follow-up at the cardiac surgeon ' s office in one week. A review of the resident ' s September 2018 Treatment Administration Record (TAR) revealed from 9/12/18 (to 9/19/18) an order to cleanse the distal end of the surgical incision and pack with wet to dry dressing was only scheduled once daily at 7:00 AM each day. The TAR indicated the dressing should be changed every day and "as needed every day shift for surgical care". Further review of the September 2018 TAR revealed the treatment was completed once daily on 9/13/18, 9/16/18, 9/17/18, and 9/19/18. However, treatment for the surgical incision was not documented as completed (or refused by the resident) on 9/14/18, 9/15/18, or 9/18/18. Resident #1 ' s medical record included a Progress Record dated 9/19/18 from another consultation with her cardiac surgeon ' s office. This record reported the resident was seen for a sternal wound check. The record indicated her sternal wound was not progressing as desired and appeared to have become bigger in size as well as deeper. The wound was noted to have slough as well as a scab. Recommendations made from the surgeon ' s office included applying and changing wet to dry dressings twice daily. A return follow-up was scheduled for two weeks.	F 684	call. This process will ensure daily monitoring. This monitoring will be on-going. Negative findings will be addressed when/if noted. The results of the clinical start up meeting and weekend monitoring of consulting physician orders and medication/treatment record completion will be reviewed by the Interdisciplinary Team weekly times 4 weeks, biweekly times 2 and monthly times 3. Additional interventions will be implemented by the Interdisciplinary Team if deemed necessary. Monitoring: The results of the weekly, biweekly and monthly audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months to determine the effectiveness of this plan. The Quality Assurance Performance Improvement committee will monitor for any negative patterns/trends. Additional interventions will be developed and implemented as needed to sustain substantial compliance. The Administrator is responsible for implementation of this plan of correction.	

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A review of the resident ' s September 2018 TAR revealed on 9/19/18 an order to cleanse the distal end of the surgical incision and pack with wet to dry dressing was scheduled twice daily each day at 7:00 AM and 3:00 PM. Further review of the September 2018 TAR revealed the treatment for Resident #1 ' s surgical incision was not documented as completed (or refused by the resident) on 9/20/18 at 3:00 PM, on 9/21/18 at 3:00 PM, 9/24/18 at 3:00 PM, 9/25/18 at 3:00 PM, 9/26/18 at 3:00 PM, 9/27/18 at 7:00 AM, or 9/27/18 at 3:00 PM.

A grievance report dated 9/24/18 and filed on behalf of Resident #1 was reviewed. The report indicated concern was expressed by a family member in regards to Resident #1 ' s dressing changes. The documentation of the grievance/complaint and facility follow-up report was authored by the facility ' s Administrator and Director of Nursing (DON). Two missed treatments were acknowledged as having been missed at that point in time. The facility initiated a practice to place the 2nd shift wound care treatments on the resident ' s Medication Administration Record (MAR) to ensure the 2nd shift nurse would not miss seeing that a treatment was due. Further review of Resident #1 ' s September 2018 TAR and MAR revealed this practice was initiated on 9/28/18.

A telephone interview was conducted on 10/31/18 at 1:35 PM with the facility ' s Medical Director, who also served as Resident #1 ' s physician. When asked, the physician confirmed Resident #1 ' s cardiac surgeon was the primary physician for her incision wound care. He reported the recommendations made from that office were the wound care orders that he would have intended

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to be initiated and followed.

An interview was conducted on 10/31/18 at 4:40 PM with the facility ' s Administrator and Assistant Director of Nursing (ADON). During the interview, the facility ' s former wound care nurse (Nurse #2) was identified as the staff member who had transcribed Resident #1 ' s 9/12/18 wound treatment orders as once daily (versus three times daily as recommended by the cardiac surgeon ' s office). Upon inquiry, the ADON stated her expectation "would be for it (the wound care recommendation) to be called to our MD (Medical Doctor), verified, and transcribed as written."

During the interview conducted on 10/31/18 at 4:40 PM, the Administrator and ADON reported the facility did identify two missed wound care treatments for Resident #1. They stated the facility started including wound care treatments needing to be done by the 2nd shift nurse on the resident ' s MAR to alert nurses to complete these. When asked, the Administrator reported no plans were currently in place to ensure wound treatments were completed in accordance with physician ' s orders or to involve the Quality Assurance and Performance Improvement (QAPI) committee. Upon inquiry, the Administrator stated she would have expected wound care treatments, "To be done as ordered."

A telephone interview was conducted on 11/5/18 at 3:04 PM with the Nurse Practitioner (NP) who saw Resident #1 while she was followed at the cardiac surgeon ' s office for wound care. Upon inquiry, the NP reviewed the progression of the resident ' s wound and wound care recommendations/orders from her office visits, including the 9/12/18 office visit. Upon review of

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her records, the NP stated it was determined at the 9/12/18 office visit that the resident ' s wet to dry dressing needed to be completed three times daily. This recommendation was relayed in writing to the facility. When the NP was asked if she recalled having any calls or communication from the facility with questions, concerns, or possibly a change of orders to the wound care, the NP stated, "Absolutely not."

A telephone interview was conducted on 11/5/18 at 3:30 PM with the facility ' s former wound care nurse (Nurse #2). During the interview, Nurse #2 reported she did not specifically recall Resident #1. Upon inquiry, the nurse did not recall any questions (in general) being raised in relation to recommendations/orders from a surgeon ' s office about the frequency of dressing changes. When asked, the nurse reported if a resident continued to be followed by the surgeon for surgical wound care, the facility would follow the surgeon ' s recommendations as orders because the surgeon would be considered the primary doctor for that treatment.