

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

JUN 14 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713	
(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 000	INITIAL COMMENTS An amended copy was sent on 6/10/11 revised as Nurse #2 should have been identified as Nurse #3 in Example #1.	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident interview, staff interviews and Medical Director interview, the facility failed to administer pain medication for 1 of 1 sampled resident complaining of pain (Resident #320) and failed to monitor post dialysis residents for 2 of 9 sampled dialysis residents in the facility (Resident #319, Resident #175). The findings include: 1. Resident #320 was admitted to the facility on 5/24/11 with diagnoses including Osteoarthritis, Hypertension and Status Post Total Knee Arthroplasty. The Minimum Data Set (MDS) Assessment was not completed at the time of survey. The Initial Plan of Care, dated 5/25/11, identified	F 309	1. Resident #320 received Tylenol 650 mg 2 tablets @ 1700 for pain on 5-24-11. Resident was re-assessed @ 2100, Dilaudid 4mg was given by mouth per physicians order on 5/24/11. Residents attending physician completed review of current pain management regiment with resident on 5-25-11. Dilaudid 4mg has been available and administered at residents request per physician orders. Resident care plans have been reviewed and updated as indicated. 2. Facility residents were reviewed by (interviews and observation) for pain or effective pain control, using Pain Evaluation Assessment form on 6/9/11 by RCMD. Resident's identified were reviewed by attending physician for pain management and care plans reviewed and updated on 5-25-11 by Director of Nursing.	6/23/11

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

Donald B. Joseph

TITLE

Administrator

(X6) DATE

6-10-11

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

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 1</p> <p>pain as an actual problem related to the surgical site. The identified goal was to have pain alleviated with both pharmacological and non-pharmacological interventions with evidence of pain relief through both verbal and non-verbal indicators, such as grimacing, groaning, and crying thru next review. The interventional initiated were 1)to observe for signs/symptoms of verbal and non-verbal indicators of pain at each medication pass and periodically, 2) provide medications as ordered and document effective results of medication administration, and 3) notify the physician of unrelieved pain.</p> <p>Review of the Nursing Admission Assessment, dated 5/24/11, documented the resident as alert and oriented and having clear speech.</p> <p>Review of the Physician's Admission History and Physical documented the resident as alert and oriented. The Physician documented, under the heading, "Assessment and Plan," i) resident is status post left total knee arthroplasty, continue pain management.</p> <p>Review of the Pain Evaluation form, dated 5/24/11, documentation revealed that the resident was receiving PRN (as needed) pain medication. Documented under the heading, "Pain Interview - ask resident" were the following responses: a) yes I have had pain or hurting during the last 5 days, b) I frequently have pain during the last 5 days, c) yes, the pain makes it hard to sleep at night, and d) yes, my day-to-day activities are limited because of pain. The documented intensity of the resident's present pain was at 6 (scale of 0-10 with 10 being the most intense). The resident stated her goal for managing her</p>	F 309	<p>3. Facility Staff Development Coordinator provided re- education to Licensed nurses regarding assessment of resident pain, timely administration/re-assessment of medication pain medication/ effectiveness, documentation regarding pain medication (administration and evaluation of effectiveness), procedure for obtaining medication from pharmacy or back up pharmacy, procedure regarding use of E-Kit, Protocol of Physician communication (verbal/written – urgent vs non urgent) on 5-25-11 and completed on 6/17/11. In-service provided will be incorporated into Newly hired licensed employee orientation.</p> <p>Weekly for four weeks the facility Director of Nursing or designee will complete 1 to 2 random sample audits of residents identified with physician orders for pain medication to ensure that have been assessed timely, pain medication is effective and receiving pain medication per physician orders daily for four weeks.</p>		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 2</p> <p>pain or hurting would be a 3 on the 0-10 scale.</p> <p>Review of the Admission Physician Orders, dated 5/24/11, read in part, Dilaudid 4mg (milligrams) by mouth every 3 hours, as needed, for moderate to severe pain; Dilaudid 2mg by mouth every 3 hours, as needed, for mild pain; Tylenol 650mg by mouth every four hours as needed.</p> <p>Review of the Discharge note from (name of hospital) documented that the resident had received Dilaudid (pain medication) at 0930 on 5/24/11 for knee pain rated at 6 (on a pain scale of 0-10 with 10 being the most intense).The resident was re-assessed prior to discharge with a pain rating of 3/10. The resident was discharged from the hospital at 11:00AM.</p> <p>Review of the Medication Administration Record for 5/24/11 documented that the resident received Tylenol 650mg by mouth at 5:00PM after requesting medication for knee pain. The nurse documented at 5:30PM that the medication had "some effect."</p> <p>Review of the Medication Administration Record for 5/24/11 documented that the resident received Dilaudid 4mg (for moderate to severe pain) by mouth at 9:20PM after requesting medication for knee pain.</p> <p>The PRN Pain Medication Administration Record form dated 5/24/11 at 9:20PM, documented Pre-Administration of medication facial pain at a 6 (hurts even more) and Non-verbal at "B" (verbal complaints of pain).</p> <p>Review of the Nursing Notes, dated 5/24/11,</p>	F 309	<p>The Director of Nursing or designee will review facility's admission from previous day to ensure that residents identified with pain on admission have been assessed timely, pain medication is effective and receiving pain medication per physician orders.</p> <p>4. The Director of Nursing will report result of the Pain Management audits to Quality Assurance and Assessment Committee weekly for four weeks, monthly x 2, The committee will review and analyze data for trends and further action to be taken.</p>		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 3 documented that the resident was "agitated this evening." During an interview with Resident #320 on 5/25/11 at 3:30PM, she stated that on 5/24/11 she had a total knee replacement a few days ago was discharged from the hospital for rehab and arrived around lunch time. She stated that she began asking for pain medication shortly after lunch because her last medication was given around 9:00AM. She stated that she was "all over the bed" with pain and by 4:00PM she again asked for pain medication. She stated that Nurse #1 came into the room and told her that her Dilaudid was not available and that she (Nurse #1) was trying to get the medication delivered from the Pharmacy, which she said was right across the street. Resident #320 then stated that Nurse #1 gave her Tylenol around 5:00PM. The resident stated the Tylenol did not help and she again asked for stronger pain medication. She stated by this time she was crying and had called her husband to inform him that if she did not receive any pain medication soon she would call 911 to be taken to the hospital to receive pain medication. The resident stated that Nurse #1 kept assuring her that her medication would be in the facility soon. By 9:00PM the resident stated she was in so much pain she again asked for pain medication. She stated the Nurse #1 came back into her room around 9:30PM and said she borrowed medication from another resident and gave her Dilaudid for pain. Resident #320 stated that she was really hurting and crying because of the pain. She stated that she later called the Facility's hotline number to complain that she was in pain and needed pain medication. She stated the hotline number was on the paperwork left in	F 309			

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4 her room during admission.</p> <p>On 5/25/11 at 4:25PM, Nurse #1 stated that the reason she documented the resident was agitated in her Nursing Notes of 5/24/11 was because the resident was in pain. She further stated that she (the nurse) gave the resident Tylenol at 5:00PM on 5/24/11 because Resident #320 was complaining of pain and her Dilaudid (for moderate to severe pain) had not been delivered to the facility. Nurse #1 stated she called the Pharmacy to find out why the resident's pain medication Dilaudid was not in the building. Nurse #1 stated the Pharmacy needed a hard script (paper copy) of the prescription from the Physician to be faxed prior to dispensing the medication. Nurse #1 stated that she then put a note in the Physician's book at the Nursing station and called the Physician, who Nurse #1 stated was in the facility at the time and was waiting for the Physician to come write the prescription. Nurse #1 stated that Resident #320 did not ask for additional pain medication until 9:00PM. At 9:00PM, Nurse #1 walked to Hall 100 and spoke with Nurse #3 telling her that she did not have Resident #320's pain medication Dilaudid. Nurse #1 then borrowed the pain medication Dilaudid from Nurse #3's cart and gave the medication to Resident #320.</p> <p>Upon asking Nurse #1 why she did not use the Emergency Box in the facility, she stated she "did not know about the emergency box." Nurse #1 stated that Resident #320 was asking for pain medication again around midnight and she (nurse #1) told the oncoming nurse who said she would take care of it.</p>	F 309			

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 5</p> <p>During an interview with Nurse #3 on 5/25/11 at 4:35Pm she stated that Nurse #1 had come to her "frantic" on 5/24/11 around 9:00PM because her resident was in pain. Nurse #3 stated wanted to get the medication to the resident as quickly as possible so she (Nurse #3) pulled the Dilaudid (pain medication) from another resident and gave it to Nurse #1 to give to her resident. Nurse #3 further stated that Dilaudid is kept in the Emergency box and that all nursing staff knows we have an emergency medication box, where it is and what is inside of the box. Nurse #3 stated the medication is there to use for emergencies such as this when medication has not arrived from the pharmacy. Nurse #3 further stated that she doesn't know why she did not use the emergency box other than she just wanted to get pain medication to Resident #320 to relieve her pain.</p> <p>During an interview with the Director of Nursing on 5/25/11 at 4:45PM she stated that all of the nurses are trained to know there is an emergency box and they know Dilaudid is in the box. She further stated that it is expected if a resident is complaining of pain that pain medication should be administered to relieve the pain. If the pain is not relieved the Physician should be notified. If the pain medication is not available on the medication cart, the emergency box can and should be used. She stated, "no resident should be in pain."</p> <p>During an interview with the Administrator on 5/25/11 at 4:50Pm he stated that the facility is a Rehab facility and controlling pain and rehab go hand in hand. He stated that there is no excuse for a resident to be in pain.</p>	F 309		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>During an interview with Nurse #2 on 5/26/11 at 9:20AM, he stated that if the nursing staff needed pain medications that are not on the cart we have an Emergency box on station one that contains medications such as Dilaudid and Oxycondone. He further stated that if the nursing staff need to access the emergency box called the Ekit and the Physician is not in the building then we call the physician and get authorization to enter the Ekit. We enter the Ekit and have another nurse co-sign with us and also notify our physician that we entered the ebox and call our pharmacy to re-fill the ebox. The 100 hall nurse has total responsibility for the Ebox and she/he would count the medications in the Ebox with the oncoming nurse on 100 hall. He stated all the nursing staff knows about the Ekit.</p> <p>He further stated that if a new admission comes with a hard script for narcotics (pain medications) then the nurse must get a hard script written, and we have doctors in the facility everyday, all day, fax the hard script in to the pharmacy and then follow up and call the pharmacy to get the medication here. Nurse #2 stated if we call and say we need it they will get it to us - even by courier, any time day or night. If the medication is needed and we have it in the emergency kit - they follow our facility protocol and use the emergency back up.</p> <p>During a second interview with the Director of Nursing on 5/26/11 at 10:00AM she stated, "We had the medication in the facility. The Medical Director and I came up with guidelines for calling the MD. Pain is on that list. The Physician was in the facility on 5/24/11 until 10:00PM. When I</p>	F 309			

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS; CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 7</p> <p>interviewed the Nurse #1 on 5/25/11 in the evening she stated that she never called the Physician. Nurse #1 stated that she gave the resident Tylenol at 5:00pm and checked on her at 5:30pm. She stated the resident said the pain was the same and her pain level was a 6 on a scale of 0-10. The nurse did nothing about this. At 9:00pm, the resident asked for pain med and that 's when she went to the nurse on the 100 hall and asked for pain med."</p> <p>During a second interview with Nurse #1 and the DON together on 5/26/11 at 10:35AM she stated that she had not called the Physician and she knew the Physician was in the building. She stated that after giving the Tylenol at 5:00PM she reassessed the resident at 5:30PM and her pain was still the same. When the surveyor asked Nurse #1 why she did not give additional pain medication or call the physician, Nurse #1 stated she was working hard on getting the medication from the Pharmacy.</p> <p>During an interview with the Medical Director on 5/26/11 at 11:00AM she stated that this was unfortunate. She stated she did not know how or why this could have happened. She said she was in the facility until 10:00PM on 5/24/11. She stated we have a system in place and it works. She said that she was here all day; there is a physician here all day, everyday. Furthermore, when new admits come in the nurses usually come to us to write the hard script. There's always the e-box (emergency box) and the nurses know about this box to pull medications when they need them. We do not want residents in pain.</p>	F 309			

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 8 2. Resident # 319 was admitted to the facility on 5/9/2011 with diagnoses of End Stage Renal Disease, Diabetes, and Hypertension. The resident received dialysis 3 times a week. A dialysis care plan was initiated for the resident on 5/15/2011. Interventions listed in the care plan included to take vital signs each shift x 24 hours after dialysis or per MD order. A review of the facility Clinical Practice Standard for Hemodialysis, Care of Residents revealed staff were instructed to check vital signs every shift for the 24 hours post-dialysis or per MD order. An interview with Nurse #1 on 5/25/2011 at 2: 50 PM revealed nursing staff are to follow the facility Clinical Practice Standards for post dialysis residents and document vital signs on the Medication Administration Record (MAR). The nurse stated there were no standing MD dialysis orders. He indicated staff use the MAR and Clinical Practice Standard for dialysis residents. A review of Resident #319's MAR did not reveal any documentation for vital signs after dialysis.. An interview was conducted with Nurse #4 on 5/26/11 at 10:15 am. The nurse revealed staff were to document the vital signs after dialysis on the post dialysis page in the MAR. The nurse searched through the resident's MAR for the required documentation. The nurse stated there was no post dialysis page on the MAR for the documentation of post dialysis vital signs. She revealed the post dialysis documentation page had not been initiated for the resident. No documentation for post dialysis vital signs had been done since the resident ' s admission. During an interview with the Director of Nursing (DON) on 5/26/2011 at 11:05 am she stated the facility realized they had a problem with post	F 309	1. Resident #319 and #175 vital signs were checked on 5/27/11 and documented on medication administration record by assigned charge nurse. 2 All identified Hemodialysis Residents were reviewed for physician orders, for shunt checks and Vital signs per Hemodialysis Resident policy on 5-25-11 by Assisted Director of Nursing. Physician orders were obtained if indicated and placed on medication administration record. 3. Re- Education was provided to facility licensed nurse on Hemodialysis Care of Residents (SSP 1203.00) to include obtaining orders for shunt checks, Vital signs post dialysis, identification bracelet on 5-25-11 and completed on 6/17/11 by staff development coordinator. Newly hired licensed employees will be in serviced on Hemodialysis policy (SSP 1203.00)		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 9</p> <p>dialysis care. She revealed she had developed a post dialysis page for the MAR where nurses could document care. She revealed it was her expectation her nurses would follow the protocol and document care given.</p> <p>3. Resident #175 was admitted to the facility on 5/24/11 with diagnosis of end stage renal disease with hemo-dialysis.</p> <p>Review of the significant change Minimum Data Set (MDS) dated 5/11/11 coded the resident as alert and oriented and independent with daily decisions being consistent and reasonable. A review of the MDS Resident required extensive to total assistance with activities of daily living.</p> <p>A review of the care plan dated 5/12/11 revealed for an approach the resident received hemo-dialysis 3 times a week on Monday, Wednesday, and Friday. For an approach Resident #175 was to have, his vital signs checked every shift for 24 hours post dialysis or as the physician ' s orders.</p> <p>A review of the treatment sheet for the month of May 2011 revealed Resident #175 was to have vital signs post dialysis every 4 hours times 2. A review of the treatment sheet revealed Resident #175 ' s vital signs were missed on May 2, 2011, May 6, 2011, May 11, 2011, May 13, 2011, May 16, 2011, May 18, 2011 and May 20, 2011.</p> <p>During an interview on 5/26/2011 at 9:55 AM, the Director of Nursing (DON) stated the facility realized they had a problem with post dialysis care by failing to get two sets of vital signs and</p>	F 309	<p>Resident identified as Hemodialysis Resident orders will be reviewed weekly for four weeks, bi- monthly for one month to ensure that shunt checks and post dialysis vital signs are being obtained and documented on medication records by Director of Nursing or designee.</p> <p>New resident admitted to the facility identified as Hemodialysis Residents will be reviewed to ensure that shunts and vital signs are being monitored post dialysis and armbands placed per (SSP 1203.00)</p>		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 10 documenting the results on the Medication Administration Record (MAR). She stated she had developed a post dialysis page for the MAR to document the vital signs when the resident returned from dialysis.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to complete a weekly skin assessment for identified pressure areas for 1 of 3 sampled residents (Resident #175). Findings included: Resident #175 was admitted to the facility on 5/24/11 with diagnoses including osteomyelitis, three unstageable pressures ulcers, hypertension, and peripheral vascular disease, diabetes	F 314	1. Resident #175 was re-assessed by wound care nurse on 6/3/11, wound measures were obtained and documented on weekly wound pressure sheet. The responsible party and attending physician were notified of wound assessment on 6/3/11. 2. Skin assessments were completed on facility resident's to ensure that interventions were initiated as indicated and documented on proper skin report (non-pressure and/or pressure) on 6/20/11 by DON, ADON and Treatment Nurse. Care plans were reviewed and revised as indicated on 6/21/11.	6/23/11	

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(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 314	<p>Continued From page 11 mellitus, and end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS) dated 5/11/11 coded the resident as alert and oriented and independent with daily decisions being consistent and reasonable. A review of the MDS revealed the resident was admitted with three unstageble pressures ulcers. Resident required extensive to total assistance with activities of daily living.</p> <p>A review of the Care Area Assessment Review Report dated 5/12/11 revealed the resident had a history of congestive heart failure, end stage renal disease with hemo-dialysis, peripheral vascular disease, diabetes mellitus and hypertension. Resident had surgical incisions to bilateral stumps with daily washes and dry dressing to stumps and should have stump stockings with immobilizers.</p> <p>A review of the care plan dated 5/12/11 revealed for an approach the resident was to have a weekly skin assessment and document the findings.</p> <p>A review of the weekly skin assessment dated 5/10/11 revealed the area to the right ischium had 30 percent pink granulating tissue and 70 percent yellow slough. The pressure ulcer measured 7.5 by 9 centimeters (cm) with no depth and was unstageble. The weekly skin assessment for the 5/17/11 was missing from the medical record.</p> <p>A review of the weekly skin assessment dated 5/10/11 revealed the sacral area measured 4.5 by 3.2 cm with no depth. The pressure ulcer was unstageble. The area had 20 percent pink</p>	F 314	<p>3. Facility licensed staff were provided re- education in regards to weekly skin assessment of facility residents, to include weekly measurement on residents identified with pressure ulcers and action to be taken if unable to complete weekly skin assessment.</p> <p>The facility Director of Nursing or designee will make weekly rounds with treatment nurse or designee weekly for 4 weeks, bi- monthly for two months.</p> <p>The facility Assisted Director of Nursing will review treatment records weekly for four weeks to ensure that facility resident skin checks are being completed per schedule.</p> <p>This will be documented on Quality Assurance Committee wound report and weekly wound report for each resident. All residents identified with wounds will be discussed weekly in skin management action team and intervention implemented as identified.</p>		

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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345408	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/26/2011
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(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 314	<p>Continued From page 12</p> <p>granulating tissue and 80 percent yellow slough. The weekly skin assessment for the 5/17/11 was missing from the medical record.</p> <p>A review of the weekly skin assessment dated 5/10/11, revealed the left ischium area measured 4.9 by 5.3 cm with zero depth and was unstageable. The area had 20 percent pink granulating tissue and 80 percent yellow slough. The weekly skin assessment for the 5/17/11 was missing from the medical record.</p> <p>During an observation on 5/25/11 at 9:45 AM, the treatment nurse removed the dressings to observe the wounds and surrounding areas. The treatment nurse stated the wounds were healing slowly.</p> <p>During an interview on 5/25/11 at 10:00 AM, the treatment nurse stated the consultant saw the resident on 5/12/11. She further stated the wounds needed to be measured every week. She stated she had been assigned to the med cart and did not realize the wounds did not get measured on May 17, 2011. She stated when she was assigned to the med cart she could not do treatments and it just was not done.</p> <p>During an interview on 5/25/11 at 10:20 AM, the physician stated his expectation would be for the wounds to be measured weekly so he (the physician) could follow the resident's treatment.</p>	F 314			