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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 309 SS=D	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 record review and staff interviews, the facility failed to re-assess and monitor 1 of 1 sampled residents (Resident#1) who had an elevated temperature for 4 days prior to being sent to the hospital. Findings include: Resident #1 was admitted to the facility on 12/29/11 and discharged to the hospital on 09/16/12. Cumulative diagnoses included dementia, hypothyroidism and gastroesophageal reflux disease. The most recent Quarterly Minimum Data Set (MDS) assessment of 08/16/12 indicated the resident had long and short term memory problems as well as moderately impaired decision making skills. She needed extensive to total assistance for activities of daily living and was always incontinent of bowel and bladder. A physician's progress note of 08/17/12 indicated Resident #1's lungs were clear upon assessment. Resident #1's care plan was last reviewed on 08/22/12 and identified problems with activities of	F 309	**F309** Resident #1 had been discharged from the facility. There is no corrective action to be accomplished for this resident. All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) completed a list of residents experiencing an acute episode as of 11-29-12. Each of these residents has been assessed, the documentation validated and interventions reviewed to ensure appropriateness. Licensed Staff will be re-inserviced by 12-5-12 on nursing assessment, documentation, acute monitoring and our new procedure for identifying residents for acute episodes. Systemic measures implemented to ensure the alleged deficient practice does not reoccur include: A list of residents having any type of acute episode will be placed on the front of each nurses Medication Administration Record. The "acute resident list" is to alert the nurses that they are to assess, monitor and document in the medical record on these residents. The DON and/or designee will be responsible for maintaining the list and keeping it current. The licensed nurses will be responsible for adding any resident to the list that experiences an acute episode in the absence of the DON and/or designee in addition to	12-7-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Don R. Cotton	Administrator	11-28-12

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

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F 309	Continued From page 1 daily living and incontinence. The September 2012 physician's orders for Resident #1 indicated there was a PRN (as needed) order for Tylenol 325 milligrams (mg) 2 tablets every 4 hours as needed for fever. According to documentation from Nurse #1 on a vital signs and weight flow sheet found in Resident #1's closed record, she had a low-grade temperature on 09/12/12 of 99.4 degrees Fahrenheit. There was no nurse's note found indicating any assessment had been done for Resident #1. On 09/13/12, Resident #1's temperature was recorded twice on the vital signs sheet to be 100 degrees Fahrenheit by Nurse #1. According to the September 2012 PRN Pain Medication Administration Record (MAR), Resident #1 was given Tylenol 650 mg at 5:50 PM on 09/13/12 by Nurse #1. It was noted in the pre-administration section that the pain score was 5-6 indicating hurts even more. In the post administration section it was noted that the pain score was 2 indicating hurts a little bit. There was no indication as to the elevated temperature on this document. A nurse's note from Nurse #1, dated 09/13/12 at 6:20 PM, indicated Resident #1 had an oral temperature of 100.0 degrees Fahrenheit and was coughing at 5:20 PM. Her lungs were clear to auscultation throughout all lung fields. It was noted that Resident #1 complained of "just not feeling good." Her blood pressure was 144/89, pulse of 96 with respirations of 18. The note	F 309	documenting on the 24 hour shift/shift report. Licensed Staff will be educated on this process by 12-5-12. The DON and/or designee will monitor the 24-hour shift/shift report and all new physician orders to determine which residents are having acute episodes and need to be added to the list daily during the morning interdisciplinary team (IDT) meeting. The DON and/or designee will perform daily audits x 3 weeks and then random audits x 3 months to ensure that assessments, monitoring and documentation of acute episodes is being charted in the resident's medical record. The results of the daily audits will be Reviewed during the Interdisciplinary Team Meeting Monday thru Friday. Weekend audits will be reviewed on Monday. Negative findings will be addressed if noted. The Director of Nursing will bring the Results of the audits to the monthly Quality Assurance and Assessment Committee meeting x 3 month. The Quality Assessment and Assurance Committee will determine the effectiveness of the plan based on trends identified and will develop and implement additional interventions as needed to ensure continued compliance.	

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F 309	Continued From page 2 indicated Nurse #1 had administered Tylenol at 5:45 PM and would continue to monitor and recheck her temperature at 9:45 PM. Another nurse's note from Nurse #1, dated 09/13/12 at 10:16 PM, indicated Resident #1's temperature was 100 degrees Fahrenheit, blood pressure was 113/66, pulse of 96 with respirations of 18. Her lungs were clear to auscultation and she showed no signs of distress. Oxygen saturation was noted to be 91% on room air. Nurse #1 indicated she would continue to monitor. According to the September 2012 PRN (as needed) Pain Medication Administration Record (MAR), Resident #1 was given Tylenol 650 mg at 10:17 PM on 09/13/12. The pre-administration section indicated her pain was 3-4 indicating hurts a little more. The post administration section indicated her pain was 0. There was no indication as to the elevated temperature on this document. There were no nurse's notes found indicating assessments by the on-coming third shift nurse who followed Nurse #1 on 09/13/12 nor from the first shift nurse on 09/14/12. According to a 24 hour report provided by the facility for 09/13/12, it was noted by Nurse #1 in the evening remarks section that Resident #4 was running a fever of 99.5 degrees to 100 degrees Fahrenheit and her vital signs were stable. The remarks noted from night shift were "OK". On 09/14/12, Resident #1's temperature was	F 309		

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F 309	Continued From page 3 recorded on the vital signs sheet to be 99.6 degrees Fahrenheit at 4:00 PM by Nurse #1. A physician's telephone order of 09/14/12 at 4:05 PM, written by Nurse #1, indicated to collect a urine specimen for urinalysis with culture and sensitivity. A nurse's note of 09/14/12 at 4:30 PM written by Nurse #1 indicated Resident #1's temperature was 99.6 degrees Fahrenheit. The note also indicated a physician's order had been obtained to collect a urine specimen for urinalysis with culture and sensitivity. On 09/14/12, Resident #1's temperature was recorded on the vital signs sheet to be 100.9 degrees Fahrenheit at 6:40 PM by Nurse #1. On 09/14/12 according to the September 2012 PRN Pain MAR, she was given Tylenol 2 tablets by mouth at 6:40 PM by Nurse #1. On 09/14/12, Resident #1's temperature was recorded to be 99.0 degrees Fahrenheit at 8:00 PM by Nurse #1. A nurse's note written by Nurse #1 of 09/14/12 at 8:40 PM indicated Resident #1 ' s temperature was 100.9 degrees and Tylenol had been administered. On 09/14/12, Resident #1's temperature was recorded to be 99.6 degrees Fahrenheit at 9:00 PM by Nurse #1. On 09/14/12 according to the September 2012 PRN Pain MAR, she was given Tylenol 2 tablets	F 309		

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by mouth at 10:30 PM. It was noted in the pre-administration section that her pain was 5-6 indicating hurts even more. Her pain was noted as 0 in the post administration section. There was no mention of the effectiveness of the Tylenol for her elevated temperature.

On 09/14/12, Resident #1's temperature was recorded to be 101.2 degrees Fahrenheit at 10:30 PM.

A nurse's note written by Nurse #1 of 09/14/12 at 10:30 PM indicated Resident #1 had an elevated temperature of 101.2 degrees Fahrenheit. Her blood pressure was 120/73, pulse of 100 and respirations at 18. Her lung sounds were clear bilaterally and no shortness of breath noted. Oxygen saturation was noted to be 91% on room air. Her cheeks were "pink in color" and Tylenol had been given for fever. Nurse #1 also documented she had tried twice to collect a urine specimen and would it on to the night shift. Nurse #1 also indicated she would continue to monitor Resident #1. There was no documentation found to indicate anyone had rechecked Resident #1's temperature after the administration of the Tylenol at 10:30 PM.

The 24 hour report for 09/14/12, which was provided by the facility on 11/14/12, indicated Resident #1 was "OK" on day shift with no mention of her temperature status. The evening remarks included temperature of 100.9 degrees at 6:40 PM and 99.6 degrees Fahrenheit at 10:00 PM. Tylenol was given at 10:35 PM for temperature of 101.2 degrees Fahrenheit. Nurse #1 also indicated needed urine specimen as she had tried twice. The night remarks indicated no

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F 309	Continued From page 5 urine was collected and "OK" was noted with no mention of her temperature status. According to the 24 hour report of 09/15/12, day remarks indicated she was fed 100% by staff, U/A was noted (but nothing as to status of collection of the specimen). There was no mention of her temperature. In the evening remarks column it was written that the urine specimen had been collected and she was fed 75% of her meal. The night remarks section indicated antibiotic therapy, Tylenol given at 5:30 AM for temperature of 100.4 degrees Fahrenheit and to "please monitor" . An untimed physician's telephone order of 09/15/12 written by Nurse #3 indicated to collect a "STAT" (now) urine specimen for urinalysis and culture. There was no temperature documentation noted on the vital signs and weight flow sheet for 09/15/12 to indicate Resident #1's temperature was being monitored. There were no nurse's notes noted from any shift for 09/15/12. A urine culture report dated 09/17/12 for a urine specimen that was collected on 09/15/12 at 6:50 PM indicated Resident #1 had greater than 100,000 colonies of Escherichia coli indicating infection. Another physician's telephone order of 09/15/12 at 9:00 PM, written by Nurse #2, indicated to begin Cipro (an antibiotic) 500 mg twice daily for 7 days. The September 2012 Medication Administration	F 309		

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F 309	Continued From page 6 Record (MAR) for Resident #1 indicated Nurse #2 had administered the first dose of Cipro on 09/15/12. The second dose of Cipro was administered at 9:00 AM on 09/16/12 by Nurse #1 according to the September 2012 MAR. The 24 hour report for 09/16/12 indicated in the day remarks column that Cipro 500 mg was given and vital signs were 96.5 degrees Fahrenheit temperature, pulse of 84, blood pressure of 105/62 and respirations of 16. The evening remarks indicated Resident #1 had been sent out at 5:15 PM via emergency medical service. The next nurse's note of 09/16/12 written by Nurse #1 for the 7:00 AM to 3:00 PM shift indicated Resident #1 had been started on an antibiotic for a urinary tract infection (UTI) last night (09/15/12). The note indicated Resident #1 had slept most of the shift except when awakened by the nurse or the nurse aide. Her blood pressure was noted to be 105/62, pulse of 84, respirations of 18 and temperature of 96.5 degrees Fahrenheit. A physician's telephone order of 09/16/12 at 4:52 PM, written by Nurse #1, indicated to discontinue the Cipro and start Levaquin (a broad spectrum antibiotic) 500 mg daily, Albuterol 0.083% every 4 hours and as needed and obtain a chest xray. A physician's telephone order of 09/16/12 at 5:10 PM, written by Nurse #1, indicated to send Resident #1 to the emergency room for evaluation.	F 309		

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F 309	Continued From page 7 A nurse's note written by Nurse #1 of 09/16/12 at 5:12 PM indicated she had assessed Resident #1 and her oxygen saturation was down to 77% on room air with a heart rate of 140. The physician was notified and she was transported out of the facility at 5:15 PM. Nurse #1 was interviewed on 11/13/12 at 3:15 PM. She stated she remembered working with Resident #1. Nurse #1 reported when resident's had low-grade temperatures for more than 2 days she notified the physician. She added that if the temperature remained elevated after the administration of the Tylenol, she would telephone the physician. Nurse #1 stated Resident #1 had an on-going low grade temperature when she worked with her. She stated she reported it to the on-coming nurse at the end of her shift. She stated she also recorded it on the 24 hour report which was available for the nurse to review. Nurse #1 reported she had telephoned the physician on 09/14/12 early in the shift to report her elevated temperature. She stated the physician told her to continue the Tylenol and collect a urine specimen. When questioned if she had called the physician back when Resident #1's temperature was 101.2 degrees Fahrenheit, she responded she had already talked with the physician earlier and was told her to continue the Tylenol so she did not. Nurse #1 reported that on 09/16/12 she could not remember if Resident #1 was coughing or not as she was more focused on her breathing since her oxygen saturation had dipped to 77%. She stated she did remember listening to her lungs before sending her out and her face was pink in color.	F 309		

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F 309	Continued From page 8 The RCS (RCS#3) who worked with Resident #1 on second shift 09/13/12 was interviewed on 11/13/12 at 4:30 PM. She stated she remembered Resident #1 as being incontinent with stiff legs. She stated she had a wet rattling cough and an elevated temperature when she worked with her. RCS#3 stated she notified the nurse of the cough and the temperature but she didn ' t know what the nurse did about it. The Director of Nurses (DON) was interviewed on 11/14/12 at 9:00 AM. She stated there was no protocol for administration of Tylenol. She stated residents have PRN orders for Tylenol and staff administer per their discretion. The DON stated if a resident spiked a temperature, the nurse should administer the Tylenol, document she gave it and recheck the resident ' s temperature about an hour after the Tylenol to assess effectiveness. The DON stated the least she would expect staff to do was to check Resident #1's temperature every shift to see if the temperature was resolving. She also commented she expected the nurses to document effectiveness of the Tylenol on the back of the Pain MAR. The DON reported she reviewed all of the 24 hour reports each morning. She stated that each completed 24 hour report was filed in her office and not available on the halls for review by the nurses. She added that it was not part of the resident's medical record. The DON stated the elevated temperature should be documented on the 24 hour report and it should be passed on to the on-coming shift nurse for monitoring and assessment. She added if the temperature did not decrease, the nurse should telephone the physician for direction. The DON stated each shift nurse should be monitoring the temperature	F 309		

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and documenting in the resident's record. She commented that staff only chart by exception meaning that only changes in condition were noted. The DON remarked if residents were receiving antibiotics, staff were expected to do a full set of vital signs each shift and document whether resident was having any adverse side effects from the medication. She stated if a resident was having respiratory issues, staff should be assessing lungs, coughing, wheezing and document in the nurse's notes.

A telephone interview was conducted on 11/14/12 at 10:48 AM with the day shift nurse (Nurse #3) who had worked with Resident #1 on 09/13/12 and 09/14/12. She stated she had worked with Resident #1 but didn't remember her having any issues with coughing or elevated temperatures. She stated the 24 hour report was available for review. Nurse #3 stated if it was reported to her that a resident had an elevated temperature, she would recheck the temperature one hour after she administered Tylenol. She commented if Tylenol was given it would be documented on the PRN pain sheet. Nurse #3 stated if a resident's temperature was greater than 101 degrees Fahrenheit, she would telephone the physician. When questioned about assessment of Resident #1, she commented that she usually "looked" at her during medication administration in the mornings. Nurse #3 stated she documented only when there was "something going on" with the residents but she did not remember anything further about Resident #1.

RCS #2 was interviewed on 11/14/12 at 11:30 AM. She stated she had worked with Resident #1 on 09/14/12. She stated Resident #1 was

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quiet and confused. RCS#2 stated she did have a cough and a runny nose. She added that she did inform the nurse. RCS#2 stated she did not remember if she had a temperature or not when she worked with her that day.

The nurse (Nurse #4) who had worked with Resident #1 on first and second shift on 09/15/12 was interviewed on 11/14/12 via telephone at 1:30 PM. She stated she had worked with Resident #1 in mid September 2012 but did not remember anything about the resident or her condition. She commented if a resident was running a temperature even if was a low-grade temperature, she would do a full assessment of the resident. She stated she would pass it on to the on-coming shift nurse for them to monitor as well. Nurse #4 stated if resident's had temperatures, she was to document it in the resident's chart and on the 24 hour report.

The RCS (RCS#4) who worked with Resident #1 on day shift on 09/15/12 was interviewed on 11/14/12 at 2:10 PM. She stated she did not remember Resident #1 being sick when she worked with her. RCS#4 reported she had declined but she could not remember any specifics other than she was total care. She commented if resident's had temperatures she reported it to the hall nurse.

An interview was conducted on 11/14/12 at 9:45 AM with the Resident Care Specialist (RCS) aide who had worked with Resident #1 on third shift on 09/15/12. She stated she had worked with Resident #1 that night and she was running a temperature. She stated her temperature was taken but she didn't document it anywhere and

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didn't remember what the reading was. She stated Resident #1 was not capable of relating how she felt but the RCS could tell by looking at her that she didn't feel well. The RCS stated "her eyes looked weak", she was warm to touch and was coughing. The RCS stated she notified the nurse. She added that she did not notice any changes in her urine.

Nurse #2 was interviewed on 11/14/12 at 9:50 AM. She stated she had worked with Resident #1 on third shift on 09/15/12. Nurse #2 stated Resident #1 had gotten sick and was sent out to the hospital. Nurse #2 stated she had received the urine culture report and had reported the results to the physician. She stated she administered Tylenol to residents depending upon their conditions and it was varied as to how and when she gave it. Nurse #2 stated if a resident had a low-grade temperature of 99.1 degrees Fahrenheit she would not be overly concerned unless it didn't resolve. When questioned about an on-going low-grade temperature for several days, she stated she would probably give Tylenol and if that was not effective, she would telephone the physician. Nurse #2 commented that temperatures should be checked after the administration of Tylenol to determine if Tylenol had any affect on the elevation. When questioned about assessment of Resident #1, she stated did not document any assessment in the nurse's notes. She also stated she probably should have assessed her and documented her findings in the nurse ' s notes in her chart but on third shift most of the resident's were sleeping. Nurse #2 stated she woke Resident #1 up around 5:30 AM to give her medications. She commented that she did

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	345332	A. BUILDING _____ B. WING _____	C 11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB	2501 DOWNING STREET SW WILSON, NC 27895

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 document the elevated temperature on the 24 hour report but not in the resident's record. Nurse #2 also reported not remembering whether Resident #1 had a cough or not. When questioned as to receiving report from the off-going nurse (Nurse #1) on 09/15/12, she stated report was given at the beginning of every shift by the off-going nurse.	F 309		