Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0266	A. BUILDING: _____ B. WING _____	C 05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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) COMPLETE DATE
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observation, record review, and staff interviews, nursing staff failed to administer medications within 60 minutes of the scheduled time for 7 of 32 residents (#4, #5, #6, #7, #8, #9, #10). Findings included: Review of facility "Medication Administration Procedure" dated June/2008 stated: "Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by physician. For example, if the medication is ordered for 8:00 AM., it must be given between 7:00 AM and 9:00 AM in order to be considered timely." Review of "Medication Administration in the Nursing Facility" by the American Society of Consultant Pharmacists dated November/2012 stated: "Once a time is assigned, the nurse or aide has 60 minutes before and 60 minutes after the designated time to administer the medication. For example, if "once a day" is designated to be 9:00 AM by policy, the dose may be administered between 8:00 AM and 10:00 AM." During an observation of a medication pass on 05/18/15 at 8:00AM, Med Tech #1 was observed not completing her 8:00 AM medication pass in the Adult Living Facility (ALF) by 9:00 AM. It was observed that at 9:07 AM Med Tech #1 still had 4	D 364	D364 No ill effects were observed for the residents who received their medication outside the accepted parameters. The alleged deficiency was corrected on 5/20/2015 by scheduling 2 Medication Technicians to administer medication in the Assisted Living wing. All Assisted Living residents have the potential to be affected by this alleged deficient practice. The DON or ADON will ensure 3 staff members are scheduled for the 40-bed ALF unit for first shift when people need to be gotten up and dressed and ready for meals around medication times. The DON and ADON will observe med pass on each shift weekly for 4 weeks to determine needed changes in staffing. Monitors of second and third shifts show that they can accomplish the med pass in a timely manner with 2 staff members on the hall. The DON or ADON will report monitor results to the QAPI committee during regular meetings for the next 4 months. The committee will evaluate the effectiveness of the plan and make recommendations as needed.	6/17/15

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

Preparation, submission and implementation of the Plan of Correction does not constitue an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

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D 364	Continued From page 1 residents (#4, #5, #6, and #7) left to pass medications to in order to complete her 8:00 AM med pass. Med Tech #1 stated, "with 32 residents to pass meds to and only one Med Tech to do the job, it was hard to complete med pass most days." During an observation of a second medication pass on 05/19/15 at 9:06 AM, Med Tech #2 was observed not completing her 8:00 AM medication pass in the Adult Living Facility (ALF) by 9:00 AM. It was observed that at 9:06 AM Med Tech #2 still had 3 residents (#8, #9, and #10) left to pass medications to in order to complete her 8:00 AM med pass. Med Tech #2 stated, "I help with getting residents up for the day; also, I am responsible for completing med pass on 2 med carts. She said, "It is very hard to complete med pass with only one CNA to help me with the 7 AM - 3 PM shift for 32 residents" . She further explained, "There used to be two Med Techs scheduled at 8:00 AM (one for each med cart) which allowed them to finish their med rounds within the allotted time." During an interview with resident #1 on 05/19/15 at 4:18 PM, he stated: "My medications are almost always given late," and that he was not sure why his medications were not given on time. During an interview with the ADON on 05/19/15 at 4:43 PM, revealed that it was her expectation that all medications be given no later than 60 before the dosing time or 60 or no later than 60 minutes after the dosing time. During an interview with the DON on 05/18/15 at 12:30 PM she revealed that it was her expectation that all medications be given no longer than 60 minutes prior or 60 minutes after	D 364		

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D 364	Continued From page 2 their scheduled dosing, per facility policy.	D 364		