PRINTED: 04/27/2016 FORM APPROVED OMB NO. 0938-0391

		(X3) DATE SURVEY COMPLETED			
		345149	B. WING		C
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIANCT	R HEALTH & RETIREME	NT		4911 BRIAN CENTER LANE	
				WINSTON-SALEM, NC 27106	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E COMPLETION
F 241 SS=D	manner and in an enenhances each resid full recognition of his This REQUIREMENT by:  Based on record rev staff interview, the far in a dignified manner embarrassment, frust of 4 residents (Resident #6 was adm 2/26/16 with multiple respiratory failure, masyndrome, anxiety, and admission MDS dater cognition was intact a with all activities of dof eating. She was in behavioral symptoms days during the 7 day behavioral symptoms 1-3 days during the 7 behaviors were indicated and the form of the second of t	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.  The is not met as evidenced sew, resident interview, and cility failed to treat a resident resulting in feelings of ration, and disrespect for 1 ent #6) reviewed for dignity.  In the individuality on diagnoses including astocytosis, chronic pain and depression. The individual disrespect for 1 ent #6) reviewed assistance ally living with the exception dicated to have verbal directed toward others and she required assistance ally living with the exception dicated to have verbal directed toward others not directed toward others have period. The steed to have no impact on the staff treated her with he stated the Director of simes embarrassed her and indicated the DON would divinat's that Ms. {Resident	F 24	1) Resident #6 was interviewed by Facility administrator on 3-15-1 The resident interview was documented on a resident concern form, to include	d a ct ator. as by  ft  y,
	#6] want now. When recall any specific exa	n asked if she was able to amples with the DON,		and monthly thereafter for five months.	
ABORATORY D	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

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.

**Electronically Signed** 

04/18/2016

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 241	the exact date, but at her room with the DO (NP). She stated she what they were discuthem about some correvealed the DON unthe bottom of his shirth his bare skin and stat show you what a real Vietnam and had real she did not know how She stated she felt thalso felt as if he migh her concerns. She refor her and made her express herself becaus he stated she had n with the DON or other An interview was considered to the lifted it up to the area and stated she was unable She indicated she was the DON. She stated discussing some concrecall the exact concert the NP revealed the lifted it up to the area and stated something from being a veteran, was exposed on his ethe DON had his shirt two and then proceed. The NP stated there we the DON to expose his	ne was unable to remember about a week ago she was in the and Nurse Practitioner addn't remember exactly sing, but she was informing ocern she had. Resident #6 tucked his shirt and pulled to up to his neckline exposing ed something like 'let me problem is, I was in problems'. She indicated to to respond to the DON. is was inappropriate and to have been making fun of evealed this was frustrating feel like she was unable to use she was not respected, of shared these feelings a staff. In ducted with the NP on the NP confirmed the dent #6 had shared the DON had occurred. She is in Resident #6's room with Resident #6 was beens. She was unable to the staff. In the NP confirmed the dent #6 had shared the DON had occurred. She is in Resident #6's room with Resident #6 was beens. She was unable to the staff had underneath his breast bone about the scars he had She indicated his bare skin interestomach. She stated lifted for only a second or ed to tuck his shirt back in was no medical reason for	F	Q M A T	Audits will be presented to quality Improvement Committee for review, by the administrator for six months. The committee will make revisions to the plan as indicated as a single plan as a si		

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F 241	it with the Administrat An interview was cond 3/30/16 at 3:45 PM. specific incident Residinvolving himself and stated he recalled beil when she was discussiomach or breast regiffe wanted to show his breasts and she begastated he asked her in Resident #6 said som don't know what it fees shared with Resident Vietnam and understowas unable to recall it room at that time. The denied lifting up his stomach to Resident also stated that Resident also stated that Resident was unable to recall it room at that time. The denied lifting up his stomach to Resident also stated that Resident also stated that Resident also stated that Resident and said. He denies such as, 'oh lord what now'.  An interview was condadministrator on 3/30. Administrator indicate specific incident Resident involving the DON, but was also present durit he spoke to Resident and she informed him	scussed the incident ON and she had not shared for. ducted with the DON on The DON indicated the dent #6 had shared the NP was inaccurate. He ing in Resident #6's room sing something about her gion. He indicated Resident m something under her an to lift up her clothing. He not to do that. He indicated nething to the effect of 'you les like'. He stated he then #6 that he had been in bod pain. He indicated he f anyone else was in the le DON reiterated that he hirt to expose his bare #6 and the NP. The DON lent #6 had never informed lassed or upset by anything led making any statements at's that [Resident #6] want ducted with the /16 at 4:00 PM. The led he was aware of the	F 2	PEFICIENCY)		
	Resident #6 had not s	shared with him any				
	negative feelings such					
		ing respected. He indicated at at no time had she felt				
	resident #0 stated the	at at no time had she lest				

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F 241 F 281 SS=D	Continued From page unsafe at the facility. also spoke with the DHe stated the DON dexpose his bare skin indicated he had not the incident as he wa involvement. The Addiscrepancies in the sby Resident #6 and the reiterated that Reside negative feelings with stated he had addres had been resolved. 483.20(k)(3)(i) SERVI PROFESSIONAL STATE The services provided must meet profession. This REQUIREMENT by:  Based on record revifacility failed to obtain by the physician for o (Resident #5 was admitted with multiple diagnose.	The Administrator stated he iON regarding the incident. enied lifting up his shirt to to Resident #6. He spoken to the NP regarding is unaware of her ministrator reiterated the statements of events as toldine DON. He additionally ent #6 had not shared her in him. The Administrator is sed the incident and felt it ICES PROVIDED MEET ANDARDS in all standards of quality.  It is not met as evidenced lews and staff interviews, the laboratory work as ordered ne of three residents ed for labs.  In the Administrator is a sevidenced lews and staff interviews, the laboratory work as ordered ne of three residents ed for labs.  In the Administrator is a sevidenced lews and staff interviews, the laboratory work as ordered ne of three residents ed for labs.  In the Administrator is a told in the interviews is a sevidenced in the interviews in the interviews is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the interview is a sevidenced in the interview in the inter	F:	241	1) Resident # 5 no longer resides in facility. 2) The Director of Nursing or Designee will complete an audit to ensure that residents' physician lab orders had been scheduled or obtained. The audit was initiated or obtained. The audit was initiated or will provide re-education to the facility licensed nurses, inclused the facility procedure for scheduling labeled to the state of the facility procedure for scheduling labeled to the facility procedure for scheduling labeled t	the  ding ng the abs. the	4/27/16
111111111111111111111111111111111111111	2012 stated requested documented in the La or designated record.	boratory Request Log Book			Conduct random resident lab aud ensure that labs are scheduled ar obtained per physician orders. Fix residents will be audited weekly four weeks and monthly thereafter for five months	nd re	

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		345149	B. WING		1 03/	30/2016
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F 281	Count (CBC) and Bas one week.  A review of the reside 3/30/16 revealed no I BMP.  A review of the Labor revealed no documer dated 3/8/16 requestid drawn for Resident #5  An interview with the Manager was conducted She stated the physic requesting a CBC and week for Resident #5  Laboratory Request I Manager stated she of document all request Laboratory Request I laboratory Request I laboratory staff refer to Log Book to identify stated the CBC and to for Resident #5 as on An interview with the conducted on 3/30/16	enich read Complete Blood sic Metabolic Panel (BMP) in sent 's medical chart on ab results for a CBC or a satory Request Log Book neation of the physician ordering a CBC and a BMP to be 5.  Second Floor Unit Nurse sted on 3/30/16 at 10:03 AM. stan order dated 3/8/16 d a BMP to be drawn in one was not documented in the Log Book. The Nurse expected the nursing staff to se for laboratory work in the Log Book. She stated the stothe Laboratory Request shysician lab orders. She he BMP were not obtained dered by the physician.  Nurse Practitioner (NP) was 6 at 1:30 PM. The NP stated lity to obtain laboratory work	F 2	4. Findings of the audits will be	/ill	
F 333	was conducted on 3/3 stated he expected the	Director of Nursing (DON) 30/16 at 3:46 PM. The DON se nursing staff to document ab work in the Laboratory ENTS FREE OF	F 3	33		4/27/16
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F 333 SS=D	This REQUIREMENT by: Based on record revi interview, and pharms facility failed to maints antianxiety medication resulting in the omiss medication for seven residents (Resident # The findings included  Resident #7 was adm with multiple diagnose Her admission Minime dated 3/10/16 indicate and she received anti seven out of seven daperiod.  An interview was cone AM with Resident #7. missed several doses medication) since her facility reportedly didnindicated staff told her arrived from the pharmshe didn't know why if receive a medication indicated she spoke to Nurse Unit Manager (and she stated she with the stated she was to the service of the stated she was the service of the stated she was the service of the stated she was the service of the service of the stated she was the service of the	are that residents are free of ation errors.  This not met as evidenced few, resident interview, staff facy staff interview, the facility of the antianxiety doses for one of three for ordered by the physician from the antianxiety doses for one of three for medications.  This including bipolar disorder.  The cognition was intact anxiety medications on any during the look back ducted on 3/30/16 at 8:30.  The revealed she had of her Klonopin (antianxiety admission because the facility on the klonopin had not macy. Resident #7 stated	F	333	<ol> <li>Resident #7's attending physicia was notified on 3-21-16 of the omission of Klonopin on the 3/19 thru 3-22-16 by Director of Nursin The attending physician ordered resume the Klonopin 0.5mg on 3-2). A Facility audit will be completed Residents' current Medication Administration Records to ensure each medication is/was available is/was administrated.</li> <li>The Director of Nursing or designed will provide re-education to the licensed nurses on reordering medication and procedure to follow if medication is not available re-education will be initiated on Ap 18 and completed on April 27 and include all licensed nurses includin PRN and weekend. Licensed staff who do not receive the re-education by 4/27 will be re-educated prior to the next shift worked. An audit will be conducted by the Director of Nursing or designee of five residents Medication Administration Records to ensure that medication are available and being administrated Audits will be conducted weekly for four weeks and monthly for five months</li> <li>Findings of the audits will be reported to Quality Improvement Comby the Director of Nursing monthly for six months. The committer review the results and determine furth monitoring is indicated</li> </ol>	ng. to -22-16. d of that and ee ng e. The oril g n s ted,		

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F 333	The medical record w #7. A Physician's On Klonopin 0.5 milligrar Resident #7.  The March 2016 Med Record (MAR) for Re The MAR included th twice daily. Further in Resident #7 was not dose of Klonopin on 3 administered either of 3/21, or 3/22. The M following notations:  3/19/16, 3-11, Kl notified, [Nurse #1]  3/20/16, 4p, Klor aware, [Nurse #1]  3/21/16, 8:00A, H from pharmacy, [Nurse A Nursing Progress N resident called for assidiscomfort in her chece (NP) completed an accorders.  A Physician's Order v 3/21/16 at 8:50 PM in medication) 0.5mg ever for anxiety.	vas reviewed for Resident der dated 3/4/16 indicated ins (mg) twice daily for lication Administration sident #7 was reviewed. e order for Klonopin 0.5mg eview of the MAR revealed administered the second 3/19 and was not ose of Klonopin on 3/20, AR also indicated the onopin 0.5mg, pharmacy inopin 0.5mg, pharmacy (lonopin 0.5mg, on order se #2]  Idote dated 3/21/16 indicated sistance stating she had st. The Nurse Practitioner issessment and wrote new with a time and date of dicated Ativan (antianxiety very four hours as needed					
	AM with the SF Nurse #7 had informed her s administered several because the facility w	ducted on 3/30/16 at 9:30  E UM. She stated Resident  She had not been  doses of her Klonopin  as out of it. The March  int #7 was reviewed with the					

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F 333	around the letter on the medication was not a revealed Resident #7 second dose of Klono administered either of 3/21, or 3/22. The Stunable to say why the new prescription from running out of the Kloobtaining a new prescription from the SF Nurse UM. So a controlled substance prescription from the medication ran out. So prescription was to be physician by a nurse medication. She state She indicated any nuthe Klonopin to Reside the amount of Klonopin for Restated she was unable prescription f	tated if there was a circle the MAR it indicated the dministered. The MAR was not administered the opin on 3/19 and was not ose of Klonopin on 3/20, Nurse UM stated she was e facility had not obtained a the physician prior to onopin. The procedure for cription was reviewed with the stated that Klonopin was the and required a new physician each time the she indicated the e requested from the prior to the depletion of the ed this was a team effort, the see who had administered tent #7 had been aware of in remaining. The SF Nurse requested a new physician prior to running the stated that #7. She additionally the to say why a new bin had not been received the total why a new bin had not been received the total why a new bin had not been received the total why a new bin had not been received the total why a reviewed the total the medication was the MAR revealed Resident red the second dose of the was not administered either	F	333			

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F 333	physician and ordered running out of the curstated his expectation administration of med running out of the me stated he was unable prescription of Klonop the same day it was in the stated the nurse who contacted the physicial was unable to be obtained and with Nurse #2. The Resident #7 was review #2 indicated she was 3/21/16. She stated the was not at the facility order at the pharmacy unable to say why an had not been received medication. She additionable to say why an had not been received to have run out. She worked on 3/19/16 or 3 not been administered because the facility who recall the exact data reviewed the medical. The NP indicated she Resident #7 for Ativameded for anxiety on She explained that states.	d from the pharmacy prior to rent supply of Klonopin. He was for no gaps in the ication caused by the facility dication. He additionally to say for sure why a new bin had not been received noted to run out (3/19/16). Working on 3/19/16 had an on-call, but a prescription wined.  Iducted on 3/30/16 at 10:05 the March 2016 MAR for ewed with Nurse #2. Nurse working on the morning of the Klonopin for Resident #7  She indicated it was on wear to running out of the tionally stated she was ew prescription of Klonopin do the same day it was noted indicated she had not	F3	33			

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F 333	that appeared to be a at that point in time si the omission of sever Resident #7. She sta order without realizing Klonopin. She indica prior to that time she order for a medication classification. She also symptoms Resident # possibly were related antianxiety medication was unable to make a two with certainty. The was for staff to notify a medication was omistated her expectation herself or the physicial prescription prior to the A phone interview was 10:45 AM with the face Pharmacy Staff #1 represcription for Klonop Resident #7 was receadditionally indicated delivered to the facility. A phone interview was 11:00 AM with Nurse are called a few days renot administered Klonof it. She stated she was 11:00 PM shift on 3/15 #7 had no available K some point during her physician on-call and Klonopin 0.5mg twice	nxiety based. She indicated the had not been notified of all doses of Klonopin for ted she wrote the Ativan g Resident #7 was on ted if she had been informed would not have written the in with the same so indicated the anxiety for experienced on 3/21/16 to her not receiving her in for several days, but she any direct link between the le NP stated her expectation ther as soon as they realized tted. She additionally in was for staff to inform an of the need for a new the depletion of their supply. It is conducted on 3/30/16 at illity is Pharmacy Staff #1. Viewed the prescription 7. She revealed a pin 0.5mg twice daily for ived on 3/22/16. She the Klonopin had been	F 3:	33		

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F 333	was unable to provide indicated she had not to provide a prescript contacted Resident # had not notified the D obtain a prescription. also working the 3:00 3/20/16 and Resident Klonopin. Nurse #1 in run out of medication procedure for obtaining write it in a binder the doctors. She indicates prior to running out of no lapse in the adminishe stated this could that noticed the amourunning low. Nurse # instance, no one com An interview was con-Administrator on 3/30 provided a facility Me (MVR) for the omission #7. The MVR indicated 0.5mg twice daily from for Resident #7. It incompared the following forms and none business day with folling form indicated notifical Supervisor/DON, Phy 3/19/16 by Nurse #1. of the error. The Adrexplain why the physiprovide a prescription daily for Resident #7 delay with the administration and the physiprovide a prescription daily for Resident #7 delay with the administration in the administration of the error.	the prescription. Nurse #1 known why he was unable ion. She stated she had not 7's attending physician and ON that she was unable to She indicated she was PM - 11:00 PM shift on #7 continued to have no indicated it was not normal to She stated the normal ing a prescription was to facility maintains for the indication so there was instration of the medication. ' ve been done by any nurse int of medication was 1 revealed that in this pleted that task.  ducted with the	F 3:	33		

AND DUAN OF CODDECTION IDENTIFICATION NUMBERS		1 ' '	X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER R HEALTH & RETIREME	NT		4	STREET ADDRESS, CITY, STATE, ZIP CODE 1911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106		
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F 333	A second interview woon 3/30/16 at 11:52 A reviewed the MVR an error. He indicated he the error, but he had with staff to address to the error, but he had with staff to address to the physician on-call of the physician's Assistant the physician on-call of 3/20/16. He stated the physician on-call of the facility contacting recall a specific reques Klonopin for Resident asked him he would've to write a prescription still awaiting approval until that time he was prescriptions for any of PA indicated he shoul for assistance with thi had not made that no the physician was the on-call physician servition who provided physician servitions and the physician servition who provided physician servitions.	as conducted with the DON M. He indicated he had d was also aware of the e had talked to staff about not had a formal inservice he concern.  s conducted on 3/30/16 at sician on-call from 3/19/16 indicated he was a (PA) and confirmed he was he weekend of 3/19/16 and at was his first weekend in le indicated he remembered him, but he was unable to est for a prescription for #7. He stated if they had e told them he wasn't able for it. He indicated he was from Medicaid (MA) and unable to write controlled medications. The d've notified his supervisor s prescription. He stated he	F	3333			
	working with the on-ca was aware the PA was to write prescriptions to He indicated the expectated that the contact him to write the	all rotation. He stated he s awaiting approval from MA for controlled medications. ctation was for the PA to be prescription. He stated e physician indicated he					

		IDENTIFICATION NUMBERS		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345149	B. WING _				C /30/2016	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT				4911 BRIAN	ORESS, CITY, STATE, ZIP CODE I CENTER LANE -SALEM, NC 27106			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
was info prescript stated the for Reside 3/22/16. The physical and the expension of the facility care of a thickness another residents unavaila the expension of the facility care of a thickness another residents unavaila this REC by:  Based of interview of the expension of the	tion for Residie Klonopin 0 dent #7 was of the indicates sician addition ware the PAtions for continup interview with the DO ontil this date of the expected supervisor to the expected the nurs of an and/or hims of the expected the nurs of the expected the nurst perfect the expected the nurst perfect the expected of the expecte	need for the Klonopin lent #7 on 3/21/16. He bent #7 on 3/21/16 or do he was unsure of the date, anally indicated the facility was unable to write rolled medications.  was conducted on 3/30/16 at N. He stated he was not that the physician on-call on was not able to write rolled medications. He do the physician on-call to so obtain a prescription and e to contact the resident's self to address the need. Its' CARE SUPERVISED BY  sonally approve in writing a stan individual be admitted to lent must remain under the cure that the medical care of ervised by a physician; and pervises the medical care of attending physician is  T is not met as evidenced liew, resident interview, staff acy staff interview, the ain physician services to	F 3	1) Renoof Kid The to 3-re Addition will by	esident #7's attending physici- otified on 3-21-16 by the Direct f Nursing of the omission of conopin on 3/19 thru 3-22-16. The attending physician ordered resume the Klonopin 0.5mg resume the Klonopi	etor d on eted of e le udit leted	4/27/16	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A, BUILDING			(X3) DATE SURVEY COMPLETED	
		345149	B. WING		C 03/30/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/30/2016
BRIAN CTR HEALTH & RETIREMENT		ł	911 BRIAN CENTER LANE NINSTON-SALEM, NC 27106		
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	meet the needs of a represcription for an an resulting in delayed of and the omission of the doses for 1 of 3 reside findings included:  Resident #7 was administed and she received antiseven out of seven deperiod.  An interview was come AM with Resident #7. missed several doses medication) since her facility reportedly didnindicated staff told her arrived from the pharmshe didn't know why it receive a medication indicated she spoke to Nurse Unit Manager (and she stated she was stated she had not he UM.  The medical record w. #7. A Physician's Ord Klonopin 0.5 milligram Resident #7.  The March 2016 Medi Record (MAR) for Resident #7.	esident who required a tianxiety medication betainment of the medication me medication for seven ents (Resident #7). The sitted to the facility on 3/3/16 es including bipolar disorder. It is important to the resident with the sincluding bipolar disorder. It is important to the resident with the set of the regular to the resident with the set of the resident with the res	F 385	3) An audit will be conducted by a Director of Nursing or designee of five random residents Medication Administration Records to ensure that medications are available and being administrated. The audits will be conducted weekly times four and then monthly for five months. The Director of Nursing will educate The Medical Director on proper Physician coverage to meet the medical care of our residents on 4-1-16. The Director of Nursing or designee will also educate all licensed Nurses, to include weekend and PRN staff on process to follow if medication is unavailable. Education will start on 4-18 and be completed on 4-27-16. Facility licensed staff that does not receive the re-education will be scheduled for the education prior to working their next shift.  4) Findings of the audits will be reported to the Quality Improvement Committee monthly for six months by the Director of Nursing. The committ will review the results and revise the plan as indicated	1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345149	B. WING		C 03/30/2016	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106			
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F 385	Resident #7 was not a dose of Klonopin on 3 administered either do 3/21, or 3/22. The Market following notations:  - 3/19/16, 3-11, Klanotified, [Nurse #1]  - 3/20/16, 4p, Klonaware, [Nurse #1]  - 3/21/16, 8:00A, Market from pharmacy, [Nurse from pharmac	administered the second w/19 and was not obse of Klonopin on 3/20, AR also indicated the choopin 0.5mg, pharmacy opin 0.5mg, pharmacy opin 0.5mg, on order e #2]  ote dated 3/21/16 indicated sistance stating she had st. The Nurse Practitioner resessment and wrote new with a time and date of dicated Ativan (antianxiety ery four hours as needed the had not been doses of her Klonopin as out of it. The March of the MAR it indicated the dministered. The MAR was not administered the pin on 3/19 and was not ose of Klonopin on 3/20, Nurse UM stated she was facility had not obtained a	F 38	35		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345149	B. WING_			C <b>03/30/2016</b>	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106			
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the SF Nurse UM. Sha controlled substance prescription from the prescription was to be physician by a nurse predication. She states he indicated any nurse the Klonopin to Reside the amount of Klonopium revealed no one represcription from the pout of Klonopin for Restated she was unable prescription of Klonopithe same day it was not administered. The #7 was not administered Klonopin on 3/19 and dose of Klonopin on 3 indicated his expectate prescription of Klonopin on 3 indicated his expectation administration of medicated his expectation administration of Klonopin on 3 indicated his expectation administration of Klonopin on 3 indicated his expectation administration of fill on physician and ordered running out of the medicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated he was unable prescription of Klonopin on 3 indicated his expectation and indicated his expectation and indicated his expe	cription was reviewed with the stated that Klonopin was e and required a new physician each time the she indicated the erquested from the prior to the depletion of the ed this was a team effort. The se who had administered ent #7 had been aware of in remaining. The SF Nurse requested a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est to say why a new physician prior to running esident #7. She additionally est t	F	885			

NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT   C(X4) ID PREFIX TAG  (EACH OF DEFICIENCY MUST BE PRECEDED BY PULL TAG  TAG  CONTINUED FROM INTERPRETATION OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)  F 385  Continued From page 16 was unable to be obtained.  An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not worked on 3/19/16 or 3/19/16 or 3/20/16.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBERS		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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BRIAN CTR HEALTH & RETIREMENT  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 385  Continued From page 16 was unable to be obtained.  An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not			345149	B. WING_		0:	3/30/2016	
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F 385  Continued From page 16 was unable to be obtained.  An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not	BRIAN CTR HEALTH & RETIREMENT		NT					
was unable to be obtained.  An interview was conducted on 3/30/16 at 10:05 AM with Nurse #2. The March 2016 MAR for Resident #7 was reviewed with Nurse #2. Nurse #2 indicated she was working on the morning of 3/21/16. She stated the Klonopin for Resident #7 was not at the facility. She indicated it was on order at the pharmacy. She stated she was unable to say why a new prescription of Klonopin had not been received prior to running out of the medication. She additionally stated she was unable to say why a new prescription of Klonopin had not been received the same day it was noted to have run out. She indicated she had not	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION	
An interview was conducted on 3/30/16 at 10:30  AM with the NP. She stated she was made aware on 3/21/16 or 3/22/16 that Resident #7 had not been administered a few doses of Klonopin because the facility was out of it. She was unable to recall the exact date she was notified. She reviewed the medical record for Resident #7. The NP indicated she had written an order for Resident #7 for Ativan 0.5mg every 4 hours as needed for anxiety on the evening of 3/21/16. She explained that staff had reported to her that Resident #7 was complaining of chest pressure that appeared to be anxiety based. She indicated at that point in time she had not been notified of the omission of several doses of Klonopin for Resident #7. She stated she wrote the Ativan order without realizing Resident #7 was on Klonopin. She indicated if she had been informed prior to that time she would not have written the order for a medication in with the same classification. She also indicated the anxiety symptoms Resident #7 experienced on 3/21/16	F 385	An interview was con AM with Nurse #2. The Resident #7 was review #2 indicated she was 3/21/16. She stated the was not at the facility order at the pharmacy unable to say why a report had not been received medication. She add unable to say why a report have run out. She worked on 3/19/16 or An interview was con AM with the NP. She aware on 3/21/16 or not been administered because the facility who recall the exact data reviewed the medical The NP indicated she Resident #7 for Ativar needed for anxiety on She explained that standard without realizing Klonopin. She indicate prior to that time she order for a medication classification. She also	ducted on 3/30/16 at 10:05 he March 2016 MAR for ewed with Nurse #2. Nurse working on the morning of the Klonopin for Resident #7 . She indicated it was on y. She stated she was new prescription of Klonopin d prior to running out of the itionally stated she was new prescription of Klonopin d the same day it was noted indicated she had not 3/20/16.  ducted on 3/30/16 at 10:30 e stated she was made 3/22/16 that Resident #7 had d a few doses of Klonopin ras out of it. She was unable te she was notified. She record for Resident #7. he had written an order for n 0.5mg every 4 hours as in the evening of 3/21/16. aff had reported to her that inplaining of chest pressure inxiety based. She indicated the had not been notified of al doses of Klonopin for itted she wrote the Ativan ig Resident #7 was on ited if she had been informed would not have written the in in with the same so indicated the anxiety	F	385			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С			
		345149	B. WING			1	30/2016	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
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F 385	Continued From page	e 17	F	385				
		to her not receiving her	1					
		n for several days, but she						
		any direct link between the						
		ne NP stated her expectation						
	•	her as soon as they realized						
		itted. She additionally						
	stated her expectation	n was for staff to inform						
		an of the need for a new						
		ne depletion of their supply.						
	A phone interview was conducted on 3/30/16 at							
		cility's Pharmacy Staff #1.						
	•	viewed the prescription						
	record for Resident #							
		pin 0.5mg twice daily for eived on 3/22/16. She	-					
		the Klonopin had been						
	delivered to the facilit	·						
		•						
		s conducted on 3/30/16 at	1					
		#1. She indicated she						
		ecently that Resident #7 was						
		nopin as the facility was out	1					
		was working the 3:00 PM - 9/16 and noticed Resident						
		Sonopin. She stated at						
		r shift she contacted the				ļ		
		requested a prescription for						
	•	daily for Resident #7. She						
		on call informed her that he						
		e the prescription. Nurse #1						
		known why he was unable						
	to provide a prescripti	ion. She stated she had not						
		7's attending physician and						
		ON that she was unable to						
		She indicated she was						
		PM - 11:00 PM shift on						
		#7 continued to have no						
	•	ndicated it was not normal to					[	
	run out of medication.	. She stated the normal						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDS	NG ,	-		
		345149	B. WING_			03/3	30/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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				١	WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 385	write it in a binder the doctors. She indicate prior to running out of no lapse in the admin She stated this could' that noticed the amourunning low. Nurse # instance, no one com  An interview was cone Administrator on 3/30 provided a facility Mer (MVR) for the omission #7. The MVR indicate 0.5mg twice daily from for Resident #7. It incerror was that a hard dispensing and none business day with folliform indicated notifical Supervisor/DON, Phy 3/19/16 by Nurse #1. of the error. The Adrexplain why the physi	ng a prescription was to facility maintains for the ed this should've been done is a medication so there was istration of the medication. ve been done by any nurse int of medication was 1 revealed that in this pleted that task. ducted with the	F	385			
	daily for Resident #7 delay with the adminis	resulting in a continued the stration of the medication outline additional doses.					
7777777	on 3/30/16 at 11:52 A reviewed the MVR an error. He indicated he the error, but he had r with staff to address the	as conducted with the DON M. He indicated he had d was also aware of the e had talked to staff about not had a formal inservice he concern. s conducted on 3/30/16 at					
		sician on-call from 3/19/16					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODERICENCY)	LD BE	(X8) COMPLETION DATE
F 385	through 3/20/16. He Physician's Assistant the physician on-call 3/20/16. He stated the on call rotation. If the facility contacting recall a specific requestion of the facility contacting approval until that time he was prescriptions for any of the facility of the specific of the should for assistance with the had not made that no assistance with the had not made that no A phone interview was 1:45 PM with Resider The physician was the non-call physician was the non-call physician weekend of 3/19/16 aworking with the on-c was aware the PA was to write prescriptions. He indicated the expectated the Klonopin of the normal prescription for Resident #7 was was 3/22/16. He indicated the physician additio was unaware the PA was prescriptions for contributions.	indicated he was a  (PA) and confirmed he was the weekend of 3/19/16 and nat was his first weekend in the indicated he remembered him, but he was unable to get for a prescription for the 47. He stated if they had we told them he wasn't able of for it. He indicated he was if from Medicaid (MA) and unable to write controlled medications. The lidity enotified his supervisor is prescription. He stated he tification.  In seconducted on 3/30/16 at an ent #7's attending physician. He supervisor of the facility's prices. He indicated the PA an on-call services on the land 3/20/16 had just began all rotation. He stated he as awaiting approval from MA for controlled medications. Sectation was for the PA to the prescription. He stated he leed for the Klonopin ent #7 on 3/21/16. He .5mg twice daily prescription written on 3/21/16 or the was unsure of the date. In ally indicated the facility was unable to write	F 3	85		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345149	B. WING		1	C /30/2016	
NAME OF PROVIDER OR SUPPLIER  BRIAN CTR HEALTH & RETIREMENT			STREET ADDRESS, CITY, STATE, ZIP CODE 4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 385	3:00 PM with the DOI aware until this date to 3/19/16 and 3/20/16 or prescriptions for contindicated he expected notify his supervisor the expected the nurs	N. He stated he was not hat the physician on-call on	F3	85			