STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING ______ B. WING ______	C 06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/GASTO	**969 COX ROAD GASTONIA, NC 28054**

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to clarify and obtain a treatment order on admission, for a resident with a below the knee amputation, for 1 of 3 residents reviewed for wound care (Resident #1). The findings included: Resident #1 was admitted to the facility on 05/17/16 with diagnoses of anemia, hypertension, diabetes and a below the knee amputation (BKA). Review of the admission Minimum Data Set (MDS) dated 05/24/16 revealed Resident #1 was cognitively intact and able to make her needs known. The MDS further revealed Resident #1 had no rejection of care during the look back period. Review of the hospital discharge summary dated 05/17/16 to the facility revealed instructions after discharge was for Resident #1 to have activity as tolerated and per surgery recommendations dressing changes every 3 days, next dressing change would be 05/20/16. If needed obtain specific instructions for dressing changes from the surgeon. Review of the Physician order dated 05/22/16 revealed: cleanse surgical incision to right below the knee amputation with wound cleanser, apply xeroform, a non-adherent, medicated gauze and wrap with kerlix, gauze bandage roll, every other day then cover with an elastic bandage wrap before applying Ampushield, a shield that provides limb protection after surgery.	F 281	Treatment order clarified and obtained for Resident #1. All Residents/Admissions identified as having the potential to be affected. Audit of all Admissions from May 17, 2016 to present completed by Director of Nursing to identify residents who may have been affected. Education/Training completed by Director of Nursing to Unit Manager(Admission Nurse) and Unit Coordinator(Treatment Nurse) related to Responsibility and Processing Orders for Admissions to ensure compliance. The Unit Manager(Admission Nurse) will maintain the responsibility of processing all physician orders, including treatment orders, for all Admissions. Admission Orders Monitoring Tool implemented to ensure compliance. Monitoring Tool to be completed by Director of Nursing on each Admission for 12 weeks. Monitoring Tool incorporated into Monthly Quality Assurance and Performance Improvement Meeting to ensure compliance and evaluate effectiveness.	7/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2016

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 281	Continued From page 1 Review of the Treatment Record (TAR) for Resident #1 revealed treatment for the right BKA began on 05/22/16. During an interview conducted on 06/09/16 at 1:49 PM the Treatment Nurse (TN) stated when a new resident was admitted to the facility she performed an initial skin assessment on admission and entered treatment orders into the computer and if the resident was admitted after hours the admission nurse did the initial skin assessment and enter the treatment orders into the computer. The TN stated Resident #1 was admitted after she had left the facility and the next day the State came in to do an investigation and she was busy and did not assess Resident #1. The TN stated she was then on vacation for the next 2 days. She stated when she went into work on Sunday 05/22/16 she discovered Resident #1's dressing had not been changed and there was no order in the computer for a dressing change. The TN stated she called the nurse practitioner, who gave an order to cleanse the surgical incision to the right below the knee amputation with wound cleanser, apply xeroform and wrap with kerlix every other day then cover with an elastic bandage wrap and apply the ampushield, dressing to be changed every 2 days. The TN stated she did not know a treatment order had not been entered for Resident #1 when she was admitted to the facility. An interview conducted with the Admission Nurse on 06/09/16 at 2:31 PM revealed she admitted Resident #1 to the facility on 05/17/16 and put all of her medication orders in the computer. She stated she did not put the treatment order in the computer because it wasn't clear. The Admission Nurse stated she placed a note in the Nurse Practitioner's (NP) box to see Resident #1 the	F 281		

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F 281	Continued From page 2 next day, 05/18/16. During an interview conducted on 06/09/16 at 2:40 PM the Surgeon stated it was his expectation that the facility call his office to have an order for treatments clarified when the resident was admitted to the facility. He stated treatments needed to be done as ordered for appropriate healing of a surgical site. An interview conducted on 06/09/16 at 3:40 PM with the Nurse Practitioner (NP) revealed she saw Resident #1 on 05/20/16 and she would not let her examine her BKA of the right leg. The NP stated she was not aware there was not a treatment order for wound care and dressing changes at that time for Resident #1. She stated the TN called her on 05/22/16 and asked for a treatment order for wound care and dressing changes to be done every 2 days for Resident #1 and she gave her the order and told her to clarify it with the Surgeon's office on 05/23/16. The NP stated the treatment order on the hospital discharge summary should have been clarified when Resident #1 was admitted to the facility and put in the computer. During an interview conducted on 06/09/16 at 4:21 PM the Director of Nursing (DON) stated it was her expectation that all treatment and medication orders were to be put in the computer at the time of the resident's admission to the facility by the admitting nurse or the TN. She stated if an order was unclear it was the admitting nurse's or the TN's responsibility to clarify the order and put it in the computer.	F 281		