

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/17/2016
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview it was determined that the facility failed to provide pain medication as ordered by the physician for 1of 3 resident ' s (Resident #2) interviewed regarding pain medications. Findings include: Record review revealed the resident had a diagnosis of chronic pain, unspecified diastolic heart failure, chronic obstructive pulmonary disease, Parkinson ' s disease and restless leg syndrome. Record review revealed the physician ordered morphine sulfate 15 mg 1 tablet twice a day for pain on 5/26/16. Per review of the minimum data set assessment 6/27/16 the resident ' s brief interview of mental status score was 15, indicating that the resident was alert and oriented. Review of the medication administration record (MAR) revealed that the morphine was not available on 7/16/16 at 9:21 PM. The morphine was also listed as not available on 7/17/17 at 8:54 AM. During Interview with resident #2 at 1:40 pm on 7/17/16 he stated that the facility was out of morphine. He stated that the nurse told him that morning that they did not have any morphine at the facility and it was on order. The resident stated he was supposed to receive morphine twice a day. He stated that he was having pain in his hands. Interview with the Assistant Director of Nurses</p>	F 333	<p>Resident # 2 had medication ordered STAT on 7-17-16 by the ADON and an order for PRN (as needed) Percocet every 4 hours until the morphine arrived was obtained. Resident # 2 morphine arrived at facility on 7-17-16 and resident received his scheduled evening dose.</p> <p>All resident on pain medication have the potential to be affected. The facility a 100% audit of all pain medication orders and made sure the medications were on the medication cart and available from pharmacy. All nursing staff is being in-serviced on Ordering and Receiving medication.</p> <p>The Director of Nursing (DON)/ Assistant Director of Nursing (ADON)/ Staff Development Coordinator (SDC) and Unit Coordinator will conduct daily audits of the medication on order from pharmacy electronically via PCC (Point Click Care)to ensure they have arrived at the facility. The DON/ADON/SDC will audit the narcotic count of the medication carts weekly and if the count is becoming low they will ensure they are on order from pharmacy as appropriate. These audits will be conducted X 4 months.</p>	8/14/16

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

TITLE

(X6) DATE

Electronically Signed

08/01/2016

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.

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

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F 333	Continued From page 1 (ADON) on 7/17/16 at 3:03 PM revealed that orders were put in for Percocet every 4 hours until the MS Contin, (Morphine) arrived. She stated the resident was given Tylenol which he said was effective. The ADON stated that the resident gave out of Morphine late yesterday evening. The ADON reported that the morphine was reordered for the resident on 7/16/16. She stated that staff is supposed to pull from the striker and reorder medication from the pharmacy when the resident gets down to 4 tablets. Interview with the resident at 4:41 pm revealed that the Tylenol relieved the sharp piercing pain but the throbbing still came through. The resident stated that he requested morphine yesterday (7/16/16) twice between medications and was given Tylenol. He stated that he asked for morphine twice on 7/17/16. Interview with the Director of Nurses on 7/17/16 at 5:30 PM revealed that the resident took morphine for chronic pain syndrome. Interview with the facility pharmacy staff at 5:42 PM on 7/17/16 revealed that he had documentation of the request 6/30/16 when the morphine was filled initially and the request that was received on 7/17/16. He stated did not see any other requests for the morphine.	F 333	The results of the audits will be taken to the QAPI meeting monthly X 4 months to review for continued need for monitoring.		