STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345332	A. BUILDING _____ B. WING _____	C 06/15/2017

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

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F 000	INITIAL COMMENTS No deficiencies were cited from the complaint allegation investigation of 6/15/2017. Event ID # VIO111. Intakes NC00128476, NC00125382, NC00125265	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 157		7/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/07/2017

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F 157	Continued From page 1 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, staff, Physician Assistant and physician interviews, and record review, the facility failed to notify the physician that a prescribed liquid protein supplement was not available for one of two residents sampled (Resident #3). Findings included: A review of the medical record revealed Resident #3 was admitted 7/27/2012 with diagnoses of Parkinson's disease, low back pain, and dementia and pressure ulcer of the right ankle. The Annual Minimum Data Set (MDS) dated 10/2/2016 noted Resident #3 to be severely impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The Care Area Assessment (CAA) noted areas of concern about pressure ulcers and nutritional status, and these areas went to	F 157	Resident #3 liquid protein was administered by charge nurse on 6-15-17. The residents attending physician and Responsible Party were notified of missed doses for the month of June 2017. The facility residents who were identified with physician orders for liquid protein supplements were reviewed by the Assistant Director of Nursing to ensure that physician orders were being followed on 6-15-17. Staff Development Coordinator will provide re-education to licensed nurses regarding administration of medication per physician orders and actions to be taken if unable to administer medication on 6-15-17 and will be completed on 7-12-17. newly hired licensed nurses will receive education during orientation.	

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F 157	Continued From page 2 care plan. The care plan dated 4/10/2017 noted a focus of potential for nutritional problems related to poor intake. The goal was Resident #3 would have not significant weight changes through next review. The interventions included: due to significant weight loss, Resident #3 receives fortified foods and supplements. On 6/15/2017 at 11:30 AM, Nurse #1 stated Resident #3 did not receive her AM supplement on 6/13/2017, nor did Resident #3 receive the AM dose of the supplement on 6/14/2017 or 6/15/2017. Nurse #1 noted she was in a hurry, she guessed, and signed the doses as given, but there was none on the medication cart. Nurse #1 stated she did not notify the physician. In an interview on 6/15/2017 at 11:45 AM, Nurse #2 stated she did not have liquid protein supplement on her cart, that there were three residents scheduled to receive it. Nurse #2 stated she would document the supplement was not given and fill out the order sheet at the nurse station so the supplement would be ordered. Nurse #2 stated she would not notify the physician. On 6/15/2017 at 12:00 noon, in an interview, Nurse #3 stated she had one resident who received liquid protein supplement, and there had been one dose on her cart. Nurse #3 stated the physician should be notified if the liquid supplement was not given. In an interview on 6/15/2017 at 1:45 PM, the facility Administrator stated he expected supplies to be ordered in a timely manner, and be	F 157	Unit Coordinator or Assistant Director of Nursing will review two sampled residents per unit to ensure that medications are being given per physician orders weekly times four and monthly x two. The results of the audits will be brought to the monthly Quality Assurance Committee meeting monthly for four months for review of need for continued monitoring.	

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F 157	Continued From page 3 available for resident's needs and physician orders In a telephone interview on 6/15/2017 at 5:35 PM, the Physician Assistant (PA) for Resident #3's physician stated she was in the facility at least three times weekly and always available by phone. The PA stated, in regard to Resident #3 not receiving the liquid protein supplement, if one dose was missed, she thought that was ok. The PA stated if it was more than one dose, the physician's office should be contacted. The PA said "if it is more than one dose, I expect to be notified."	F 157		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to maintain services to meet professional standards for two of two residents receiving supplements that were not available (Residents #3 and #4). Findings included: 1. A review of the medical record revealed Resident #3 was admitted 7/27/2012 with diagnoses of Parkinson's disease, low back pain, and dementia and pressure ulcer of the right ankle.	F 281	Resident #3 liquid protein was administered by charge nurse on 6-15-17. The residents attending physician and Responsible Party were notified of missed doses for the month of June 2017. The facility residents who were identified with physician orders for liquid protein supplements were reviewed by the Assistant Director of Nursing to ensure that physician orders were being followed on 6-15-17.	7/13/17

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F 281	Continued From page 4 The Annual Minimum Data Set (MDS) dated 10/2/2016 noted Resident #3 to be severely impaired for cognition and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The Care Area Assessment (CAA) noted areas of concern about pressure ulcers and nutritional status, and these areas went to care plan. The care plan dated 4/10/2017 noted a focus of potential for nutritional problems related to poor intake. The goal was Resident #3 would have no significant weight changes through next review. The interventions included: due to significant weight loss, Resident #3 receives fortified foods and supplements. In an observation of a medication pass on 6/15/2017 at 9:05 AM, Nurse #1 stated Resident #3 was supposed to get liquid protein nutritional supplement, but there was none on the medication cart. Nurse #1 proceeded to give Resident #3 the other medications that were ordered. Nurse #1 stated there was none of the liquid protein supplement in the facility. Nurse #1 indicated she had not worked for 3 weeks and there had been none of the supplement since she had returned to work. Nurse #1 marked the supplement as not given and in the explanation area typed "not available". Nurse #1 stated she did not call the physician. A review of the Medication Administration Record (MAR) for June 2017, revealed Resident #3 was to receive liquid protein supplement 30 milliliters (ml) by mouth twice daily at 8:00 AM and 6:00 PM. The MAR indicated Resident #3 had	F 281	Staff Development Coordinator will provide re-education to licensed nurses regarding administration of medication per physician orders weekly times four and monthly times two. The Unit Coordinator or Assistant Director of Nursing will review two sampled residents per unit to ensure that medications are being given per physician orders weekly times four and monthly x two. The results of the audits will be brought to the monthly Quality Assurance Committee meeting monthly for four months for review of need for continued monitoring.	

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F 281	Continued From page 5	F 281		

received the supplement on 6/13/2017 for both the AM and PM doses. Resident #3 had received the AM dose on 6/14/2017 and refused the PM dose on 6/14/2017. The AM dose on 6/15/2017 was indicated as "other" on the MAR.

On 6/15/2017 at 11:30 AM, Nurse #1 stated Resident #3 did not receive the AM supplement on 6/13/2017 and 6/14/2017. Nurse #1 noted she was in a hurry, she guessed, and signed the doses as given, but there was none on the medication cart. Nurse #1 stated she did not notify the physician.

In an interview on 6/15/2017 at 11:45 AM, Nurse #2 stated she did not have liquid protein supplement on her medication cart and there were three residents scheduled to receive it. Nurse #2 stated she would document the supplement was not given and fill out the order sheet at the nurses' station so the supplement would be ordered. Nurse #2 stated she would not notify the physician.

On 6/15/2017 at 12:00 noon, in an interview, Nurse #3 stated she had one resident who received liquid protein supplement, and there had been one dose on her medication cart. Nurse #3 stated the supplement comes from a different company than the pharmacy, so it is written on the order sheet at the nurses' station so it will be ordered. Nurse #3 went to the nurses' station but was unable to locate the order sheet. Nurse #3 stated the physician should be notified if the liquid supplement was not given.

In a telephone interview on 6/15/2017 at 3:50 PM, Nurse #4 stated she works the 3:00 PM - 11:00 PM shift. Nurse #4 stated she thought she had

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borrowed the liquid protein supplement from another cart when she worked on 6/13 and 6/14/2017. Nurse #4 stated Resident #3 had refused the supplement. Nurse #4 noted she would not document the supplement as given if it was not given. Nurse #4 stated there had been times in the past when there was no liquid protein supplement available.

2. A review of the medical record revealed Resident #4 was admitted 7/8/2015 with diagnoses of Diabetes, Peripheral Vascular Disease (PVD) perforation of the intestine, and peritonitis (inflammation of the lining of the abdomen).

The Annual Minimum Data Set (MDS) dated 1/26/2017 noted Resident #4 was unable to be assessed for cognition, but had no memory problems, either short term or long term, and could perform normal decision making tasks. The MDS indicated Resident #4 was independent or only needed supervision for all Activities of Daily Living (ADLs) with set up help only. The Care Area Assessment (CAA) noted an area of concern for nutritional status and pressure ulcer and these areas went to care plan.

The care plan dated 12/24/2015 noted a focus of a potential nutritional problem related to chronic disease. The goal was adequate nutritional status would be maintained as evidenced by no significant weight changes through next review. Interventions included: Observe/document/report when needed any signs or symptoms of choking, coughing drooling, and holding food in mouth. Observe/record/report to MD any signs of

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F 281	Continued From page 7	F 281		

malnutrition such as significant weight loss. Registered Dietician to evaluate and make diet change recommendations when necessary.

A review of the Medication Administration Record (MAR) for June, 2017 revealed Resident #4 was to receive liquid protein supplement, 30 milliliters (ml) by mouth twice daily at 8:00 AM and 9:00 PM. The MAR indicated Resident #4 did not receive the liquid supplement 6/14/2017 or 6/15/2017 for the AM doses. The MAR indicated Resident #4 did receive the liquid supplement on 6/14/2017 for the PM dose.

On 6/15/2017 at 11:30 AM, Nurse #1 stated Resident #4 did not receive the liquid supplement for the AM dose on 6/13/2017, 6/14/2017 and 6/15/2017. Nurse #1 noted she was in a hurry, she guessed, and signed the dose as given on 6/13/2017, but there was none on the medication cart. Both AM doses (6/14 and 6/15) were noted as "other "on the MAR and the reason was documented as not available. Nurse #1 stated she did not notify the physician.

In an interview on 6/15/2017 at 1:45 PM, the facility Administrator stated he expected supplies to be ordered in a timely manner, and be available for resident's needs and physician orders. The Administrator noted a quantity of the liquid protein supplement had been found in a facility storage building. When?

On 6/15/2017 at 2:00 PM in a telephone interview, Resident #4's physician stated he did not remember if he was called in regard to Resident #4 not receiving the liquid protein supplement on 6/14 or 6/15/2017, but he thought he was notified. The physician stated he is

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F 281	Continued From page 8 usually notified and will give an order to hold the supplement until it is available. The physician indicated he expects to be notified and usually is. In a telephone interview on 6/15/2017 at 5:35 PM, the Physician Assistant (PA) for Resident #3's physician stated she was in the facility at least three times weekly and always available by phone. The PA stated, in regard to Resident #3 not receiving the liquid protein supplement, if it was one dose missed, she thought that was ok. The PA stated if it was more than one dose, the physician's office should be contacted to see what could be done or to get an order for something else, or to, at least, inform the doctor the resident had missed the dose, but had been ordered. The PA said "if it is more than one dose, I expect to be notified."	F 281		