

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787	
(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
E 000	Initial Comments	E 000		
F 000	An unannounced Recertification survey was conducted on 02/24/2020 thru 02/27/2020. The facility was found in compliance with the requirement CFR 483.73, emergency Preparedness. Event ID NMKB11. INITIAL COMMENTS	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to obtain a Medical Doctor's order for use of oxygen for 1 of 2 sampled residents with oxygen therapy in use (Resident #18). The findings include: Resident # 18 was initially admitted to the facility on 03/19/2013 for a diagnosis of arthropathy (disease of the joint), and her last admission to	F 695	Criteria 1 Oxygen order for Resident #18 was re-activated and verbally approved by attending physician when facility was made aware of issue, and care plan was updated to accurately reflect oxygen usage. The process failure that led to the deficiency was that facility nursing staff should have verified that an order was present before placing oxygen on resident or leaving oxygen concentrator in room	3/26/20

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

TITLE

(X6) DATE

Electronically Signed

03/12/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 695	<p>Continued From page 1</p> <p>the facility was 10/01/2019 with a Diagnosis of Deep Vein Thrombosis requiring a surgical hospital admission on 09/23/2019. Other diagnosis included: Chronic Obstruction Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Atrial Fibrillation (A-fib), Fibromyalgia, and Hypertension (HTN).</p> <p>A review of a nursing note dated 10/02/2019 revealed that Nurse #2 charted Resident #18 returned via stretcher with an extensive transfer from staff. She was alert and responsive, and able to make needs known. Non-labored breathing; no adventitious lung sounds.</p> <p>A review of Resident #18 physician's orders for October, November, December 2019, and January, February 2020 revealed no oxygen order.</p> <p>A review of Resident #18 most recent Minimum Data Set (MDS) dated 02/19/2020 revealed she was cognitively intact and she received 6 days of a diuretic (removes excess fluid from the body). The MDS indicated oxygen therapy was not in use at the time of this assessment.</p> <p>A review of the Care Plan last updated 02/14/2020 revealed: Altered Cardiovascular Status related to A-fib, COPD, HTN, and CHF. The goal stated Resident #18 would be free from complications of cardiac problems. Interventions included: Observe vital signs as ordered/indicated, notify doctor of significant changes. Observe/document/report as needed any sign or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain</p>	F 695	<p>after return from hospital .</p> <p>Criteria 2</p> <p>A walking round of entire facility was completed and all residents who had oxygen usage were identified. An order listing report was obtained to verify that each of these residents had the appropriate physician's order for the oxygen being used and that the care plan accurately reflects oxygen usage. For admissions, the nurses completing admission order verifications will be required to visit the resident room to ensure oxygen equipment is present only if necessary for the admitting patient. If oxygen is necessary for admitting patient, the admitting nurse will be responsible for ensuring appropriate order is in place for any required oxygen treatment. Nursing staff will be re-educated on the requirement of a physician's order when applying oxygen to a patient, and the protocol for the admitting nurse to ensure equipment is in resident room only if necessary. This education will be performed by the DON or designee and will be completed no later than March 20, 2020.</p> <p>Criteria 3</p> <p>A walking round of 1 hall will be completed to identify which residents are on oxygen, that the appropriate equipment is in the resident's room, and that the order and care plan match what is visualized. This audit will be completed 5 x week for 2 weeks, 3 x week for 4 weeks, and 1 x week for 6 weeks. The audits will be completed by DON or designee. The results of these audits will be reported at</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 695	<p>Continued From page 2</p> <p>unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. Oxygen Settings: O2 (oxygen) via nasal cannula as indicated/ordered.</p> <p>02/24/2020 at 4:15 PM observed Resident #18 lying in bed with oxygen via nasal cannula with humidified air (using distilled water it adds moisture to prevent drying) at 3 liters in use. Resident with eyes closed.</p> <p>02/25/2020 at 9:01 AM observed Resident #18 lying in bed with oxygen via nasal cannula with humidified air at 3 liters in place. The resident reported she had been using oxygen since she was admitted in 2013 and when she came back from the hospital on 10/01/2019 the oxygen was still in her room, so she continued to ask to use the oxygen when she was in bed or up in her wheelchair.</p> <p>02/26/2020 at 8:35 AM observed resident lying in bed with oxygen via nasal cannula with humidified air at 3.5 liters in place, resident with eyes closed.</p> <p>An interview with Nurse #1 on 02/26/2020 at 8:38 AM revealed that a resident needs a doctor's order to use oxygen. She reported that Resident #18 had been on oxygen for a while now and believed she had an as needed order (PRN) for oxygen, but when she looked for the order, she could not find a current oxygen order. She reported that she would notify the doctor to get an oxygen order.</p> <p>An interview with the MDS Nurse on 02/26/2020 at 9:05 AM revealed that when she was putting the information in for the MDS she used the</p>	F 695	<p>the monthly QAPI meeting until such time that substantial compliance has been achieved and is agreed upon by the QAPI committee.</p> <p>Criteria 4 The DON is responsible for implementing the corrective actions.</p> <p>Criteria 5 The facility will be in full compliance with this plan of correction by March 26, 2020</p>		

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

PRINTED: 04/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 695	<p>Continued From page 3</p> <p>hospital's discharge summary orders. She explained that Resident #18 returned from the hospital on 10/01/2019, the MDS was coded on 10/14/2019 in the "O" section that the resident used oxygen while in the hospital, but not since she returned to the facility. She further reported that when she did her 7-day assessment prior to coding the MDS on 10/14/2019 Resident #18 was not wearing oxygen.</p> <p>An interview with Nurse #2 on 02/26/2020 at 9:55 AM that was working when Resident #18 was readmitted to the facility on 10/01/2019 revealed that when a resident returns to the facility after a hospital admission the admitting nurse would assess the resident, review the hospital discharge summary handed to them by the ambulance driver, then call the Primary Care Physician (PCP) to sign off on the new orders, and 2 nurses must verify, sign-off on the new orders, then put the new orders in the resident's chart. Nurse #2 stated she was not the nurse on Resident #18 hall and only signed as verification. She further revealed that Resident #18 only used the oxygen at night, but she did not catch that it was not on the discharge summary of 10/01/2019.</p> <p>An interview with Nurse #3 on 02/26/2020 at 10:17 AM revealed all residents that use oxygen need a doctor's order. He reported that he was not assigned to Resident #18 hall upon her admission back to the facility. He reported that he only verified the orders on the discharge summary with another nurse and he did not catch that oxygen was not ordered, so he did not remove the concentrator from her room. He further revealed that Resident #18 had used oxygen for years PRN.</p>	F 695			

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

PRINTED: 04/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 695	<p>Continued From page 4</p> <p>An interview with the Director of Nursing (DON) on 02/26/2020 at 9:42 AM revealed that all residents that use oxygen need a doctor's order. She explained that when a resident was re-admitted back to the facility from the hospital, the admitting nurse reviewed the discharge summary, and then notified the PCP to get approval for the orders, then 2 nurses reviewed the orders and put them in the chart and sign-off verifying the orders. The DON indicated the hospital discharge summary is scanned into the resident's electronic chart. She believed the breakdown occurred when Resident #18, who had a previous order for oxygen and had been on oxygen for quite a while, returned to the facility on 10/01/2019 and the admitting nurses did not catch that there was no oxygen order. The DON explained that when Resident #18 returned and there was no oxygen order, the concentrator should have been removed from her room which it was not, so staff continued to apply the oxygen when the resident asked for oxygen. The DON further explained that when a resident was discharged to the hospital all previous orders are discontinued.</p> <p>An interview with the Administrator on 02/26/2020 at 11:08 AM revealed that the admission nurse was responsible for taking off orders from the hospital discharge summary and the nurses on floor were responsible for verifying the orders. The Administrator believed the breakdown occurred when she came back from the hospital an assumption was made that there was an oxygen order. Her expectation was the nurses review the discharge orders and if no oxygen was ordered they are to remove the oxygen concentrator from the room or call the doctor for a new oxygen order. She reported that Resident</p>	F 695			

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

PRINTED: 04/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 695	Continued From page 5 #18 had been a resident for years and on oxygen for so long the staff just got used to her being on oxygen. An interview with the Medical Director/PCP on 02/26/2020 at 11:28 AM revealed that all residents using oxygen, need an order. He further revealed that Resident #18 had been on oxygen since she was admitted, and would have expected the admitting nurses to check the new orders from the hospital discharge summary to make sure oxygen was included, and if not they should have called him to get an oxygen order.	F 695			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations, Medical Director and staff interviews, the facility failed to maintain a medication error rate of 5% or less as evidence by 2 medication administration errors out of 26 opportunities. This resulted in a facility medication error rate of 7.69% which affected 1 (Resident #48) of 11 residents observed during medication administration. Findings included: Resident #48 was admitted to the facility on 10/12/15 with diagnoses which included hypertension and asthma.	F 759	Criteria 1 Nurse #4 was re-educated regarding the specific errors in the medication administration pertaining to Fluticasone Propionate 250 mcg aerosol powder and Carvedilol 3.125 mg immediately following the identification of the med error. The med error was reported as such by the DON. The process failure that led to the deficiency was that the nurse failed to read and follow the special instructions on the medication directions. Criteria 2 An order listing report was obtained to verify residents who have prescriptions for	3/26/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 759	<p>Continued From page 6</p> <p>A review of the physician orders for Resident #48 read in part: carvedilol 3.125 mg (milligrams), give 1 tablet by mouth two times a day and take with food; fluticasone propionate 250 mcg (micrograms) aerosol powder, give 1 inhalation orally two times a day and rinse the mouth after use.</p> <p>Nurse #4 was observed on 02/24/20 at 4:48 PM to be completed with the medication administration for Resident #48. The medications administered by Nurse #4 included a 3.125 mg tablet of carvedilol (an antihypertensive medication) and a 250 mcg inhalation dose of fluticasone propionate (a medication used to decrease swelling and irritation of the airways). During the observation Nurse #4 did not provide food or direct Resident #48 to eat or rinse her mouth.</p> <p>During an interview on 02/25/20 at 3:31 PM Nurse #4 indicated she read the Medication Administration Record prior to administering medications and agreed the directions were for carvedilol to be taken with food and the mouth be rinsed after fluticasone propionate. Nurse #4 confirmed she did not provide or direct Resident #48 to take carvedilol with food nor did she direct Resident #48 to rinse her mouth after inhaling fluticasone propionate. Nurse #4 explained she assumed Resident #48 would eat soon so she did not offer food. She did provide Resident #48 water so she could swallow the medications but forgot to give directions to rinse the mouth. Nurse #4 described both medication errors as being an oversight.</p> <p>During an interview on 02/27/20 at 9:20 AM the Director of Nursing (DON) explained carvedilol</p>	F 759	<p>Fluticasone Propionate aerosol powder or Carvedilol ordered by their physician. The special directions were verified to be on the bottom of the order entry. Nursing staff will be re-educated on the requirement of reading and following the special directions on all medications. This education will be performed by the DON or designee and will be completed no later than March 20, 2020.</p> <p>Criteria 3 An order listing report will be obtained to validate who takes Fluticasone Propionate aerosol powder and Carvedilol. An audit will be performed by observing medication administration of these medications on 5 residents. This audit will be completed 5 x week for 2 weeks, 3 x week for 4 weeks, and 1 x week for 6 weeks. The audits will be completed by DON or designee. The results of these audits will be reported at the monthly QAPI meeting until such time that substantial compliance is achieved and agreed upon by QAPI committee.</p> <p>Criteria 4 The DON is responsible for implementing the corrective actions.</p> <p>Criteria 5 The facility will be in full compliance with this plan of correction no later than March 26, 2020</p>		

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

PRINTED: 04/02/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER H & REHAB WEAVERV			STREET ADDRESS, CITY, STATE, ZIP CODE 78 WEAVER BOULEVARD WEAVERVILLE, NC 28787		
(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 759	<p>Continued From page 7</p> <p>should be rescheduled and given at meal times or with a snack when administered prior to meals. The DON confirmed the recommendation was to rinse the mouth after the use of fluticasone propionate. The DON stated Nurse #4 should have offered food and instructed Resident #48 to rinse her mouth as directed by the physician orders. The DON felt Nurse #4 was nervous which might have caused the errors to occur during the observation of medication administration for Resident #48.</p> <p>An interview was conducted on 02/27/20 at 9:24 AM with the facility Medical Director who revealed if not given with food carvedilol could cause a sudden drop in blood pressure and food should be given with the medication to prevent a negative side effect. The Medical Director also explained it was recommended to rinse the mouth after the use of fluticasone propionate to prevent an oral yeast infection of the mucous membranes. The Medical Director stated the nurse should follow the directions written on the physician orders to prevent negative side effects of medications.</p>	F 759			