

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

PRINTED: 03/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/12/2015
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to cover the resident's exposed body areas during the bathing activity for 1 of 2 residents observed for a bed bath, Resident #170. Findings included:</p> <p>A review of the annual minimum data set (MDS) assessment dated 01/28/2015 revealed that Resident #170 was admitted to the facility on 04/09/2015 with multiple diagnoses including diabetes mellitus, Alzheimer's disease, and benign prostatic hypertrophy. The same assessment indicated that the resident was severely cognitively impaired and was totally dependent upon staff for bathing. In addition, the MDS annual assessment indicated the resident required extensive assistance for personal hygiene.</p> <p>The resident's nursing care plan dated 01/30/2015 had a measurable goal with interventions to address his total dependence on staff for his bathing needs.</p> <p>An observation of a bath provided by nursing assistant (NA) #2 for Resident #170 was made on 02/11/2015 at 10:40 AM. NA #2 drew a basin of warm water and placed it on the resident's bedside table, then pulled back the sheet and blanket to expose the resident's entire body. The resident was wearing a disposable brief and</p>	F 241	<p>F 241</p> <p>The facility will continue to strive to promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>(NA) #2 was re- educated on Dignity and Respect of residents. The in-service included covering residents during a bath on 2/11/15 by the Staff Development Coordinator.</p> <p>(NA)#2 was observed providing care to include bed bath on 3/5/15 by the Unit Manager to ensure that the resident was properly covered while care was being performed.</p> <p>The facility direct care staff were provided re- education on Dignity and Respect of Individual., to include covering of residents during bath and completed on 3-10-15 by the staff Development Coordinator. The facility newly hired direct care staff will receive education regarding Dignity and Respect of Individual during</p>	3/10/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/06/2015
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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 241	Continued From page 1 socks only. NA #2 stepped away from the bedside to gather some other supplies, and the resident stated, "Cover me up until you get ready. I'm cold." The nursing assistant came back to the bedside and pulled up the bed sheet and blanket to cover the resident. NA #2 then washed the resident's face and shaved him, and then completely pulled back the bed covers again to wash the resident's upper chest, shoulders, arms, and upper back. Resident #2, who was still wearing a disposable brief and socks on his feet, was fully exposed a second time. The resident again stated, "I ' m cold." The nursing assistant did not respond to the resident's statement and proceeded to remove the resident's disposable brief and bathe his groin area and buttocks as the resident lay uncovered completely. During the bathing observation on 02/11/2015 at 10:40 AM, NA #2 was prompted by the surveyor to cover the resident after he had been exposed the second time. NA #2 covered the resident's lower legs and feet at that time, and continued to cleanse the groin and buttocks. When NA #2 started to wash the resident's upper thighs, he again pulled the bed covers down completely. The resident stated, "Hurry, I'm cold." NA #2 continued to wash the resident's upper thighs and did not respond to the resident's statement. In an interview with NA #2 after the bath was provided at 10:40 AM on 02/12/2015, NA #2 did not offer an explanation as to why he did not cover the resident with a sheet, blanket, or towel to cover the exposed body areas during the bath. In an interview with NA #3 at 9:24 AM on 02/12/2015, she stated that when she bathed a resident, she always covered the bare areas on a resident's body with either a towel, sheet, or blanket. NA #3 explained that she would leave exposed only the part of the body where bathing	F 241	orientation. The facility unit managers will complete 1-2 observation of facility nursing aids completed bed baths, showers and perennial care to ensure that resident dignity and respect of resident maintained to include covering of residents. The observation will be completed weekly times four weeks and bi- monthly times one. The Director of Nursing will report findings of weekly audits to the facility quality improvement committee weekly time four and then bimonthly time one... The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance. Date of completion 3/10/15		

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F 241	Continued From page 2 was being done. In an interview with NA #4 on 02/12/2015 at 9:30 AM, she stated that when she bathed residents, she covered all bare areas with a cover of some type, and that this was how she was trained. An interview with the Director of Nursing (DON) on 02/12/2015 at 5:30 PM, he stated the resident's bare areas should have been kept covered during the bath, especially since the resident stated he was cold. The DON stated the facility used Lippincott Procedures as the guide for bathing residents. A computer copy of the Lippincott Procedure Quick List for: Bed Bath (Copyright 2015, IP 96.10.23.26) was provided by the DON for review on 02/12/2015 at 5:40 PM. A review of the Lippincott procedure for a bed bath revealed the following method: Remove the patient's gown and other articles, and cover him with a bath blanket. Wash, rinse, and dry the patient's face, ears, and neck. Turn down the bath blanket, and drape the patient's chest with a bath towel. Wash, rinse, and dry the chest and axillae. Wash, rinse, and dry the patient's hands and arms; clean the nails, if needed. Turn down the blanket to expose the patient's abdomen and groin. Replace the bath blanket. Wash, rinse, and dry the patient's legs and feet; uncover one leg at a time.	F 241			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		3/10/15	

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F 312	<p>Continued From page 3 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide a complete bed bath to 2 of 2 sampled dependent residents (Resident #65 and #170) while being observed. Findings included:</p> <p>1. Resident #65 was admitted to the facility on 05/15/12. Cumulative diagnoses included hypertension, diabetes mellitus and dementia.</p> <p>The facility's undated quick list for giving a bed bath included to wash, rinse and dry the resident's genital area.</p> <p>The facility's undated procedure for providing perineal care of the female noted to provide privacy and explain the procedure. Warm soap and water was to be used to cleanse the perineum. The labial area was to be separated with one hand while the other hand washed using downward strokes from the front to the back of the perineum. It noted to use a clean section of the wash cloth with each stroke. It noted to rinse the skin thoroughly and pat dry.</p> <p>Resident #65's care plan, last reviewed on 01/24/15, identified problems with incontinence. Approaches included providing perineal care daily and as needed. Another problem identified was Resident #65 required extensive to total assistance from staff for her care.</p>	F 312	<p>F 312</p> <p>The facility will continue to strive to be in compliance with providing necessary services to include maintain good nutrition, grooming, and personal and oral hygiene to a resident who is unable to carry out the activity.</p> <p>(NA)# 8 was provided re- education on proper bathing procedures and proper perineal care on 2/11/15 by Unit Manager.</p> <p>(NA) # 8 was observed providing care to an assigned resident on 3/5/15 by Unit Manager ensuring that the resident bath was completed using proper bathing procedures.</p> <p>The facility direct care staff were provided re- education on proper bathing procedure and proper perineal care, and completed on 3-10-15 by the staff Development Coordinator. The facility newly hired direct care staff will receive education regarding Dignity and Respect of Individual during orientation.</p> <p>The facility unit managers will complete 1-2 observations of facility nursing aids for completed bed baths, showers and perineal care. The observation will be completed weekly times four weeks and</p>		

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F 312	<p>Continued From page 4</p> <p>The most recent Quarterly Minimum Data Set (MDS) assessment of 02/03/15 indicated she was not cognitively intact. She required total assistance with hygiene and bathing. She was incontinent of bowel and bladder.</p> <p>Nurse Aide #8 (NA #8) prepared to provide a bed bath to Resident #65 on 02/11/15 at 10:45 AM. She filled a basin with warm water and began the bath. She used a clean wash cloth to wash Resident #65's face and discarded the cloth into a plastic bag. She dried her face with a clean towel and discarded the towel into the same plastic bag. She changed the basin of water. NA #8 continued to bathe her arms, hands, trunk and her legs using a clean wash cloth with each part of the body washed. She discarded the wash cloths into the plastic bag. After she had washed Resident #65's legs, she changed the basin of water. NA #8 unfastened the sides of the soiled brief and pushed the brief down between Resident #65's closed thighs. As NA #8 began to use the disposable wipes to wipe each groin downward toward the perineum, it was noted that Resident #65 had a large soft stool. She discarded the wipes after each stroke. She wiped downward in the center of the mons pubis once to remove stool but made no effort to visualize the vaginal region nor open the labial folds to ensure she had removed the stool residue from the perineum. She pushed Resident #65's thighs open just enough to get her hand inside using a disposable wipe to remove the stool from inside her upper thighs. After using several disposable wipes to remove stool, she continued with the bath. She used a clean wash cloth to wash underneath Resident #65's abdominal folds and across the mons pubis and groins. She used a clean wash cloth to wash inside the upper thighs,</p>	F 312	<p>bi- monthly times one.</p> <p>The Director of Nursing will report findings of weekly audits to the facility quality improvement committee weekly times four and then bimonthly times one. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Date of Completion 3/10/15</p>		

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F 312	<p>Continued From page 5</p> <p>rinsed and dried the entire area with a clean towel. NA #8 changed the basin of water. She assisted Resident #65 to roll onto her left side. Resident #65 was noted to still have a large amount of soft brown stool which extended from her lower buttocks down to the backs of her upper thighs. She used a clean wash cloth to wash her back and a clean cloth to rinse her skin. Afterwards, she used a clean towel to dry the resident's back. NA #8 changed the basin of water and continued with the bath. NA #8 used disposable wipes to remove the majority of the stool that was visible and discarded each one. She reached inside the perineum between the tightly closed thighs to remove stool using disposable wipes. NA #8 followed with soap and water to the wash the buttocks, upper thighs and inside the tightly closed thighs. She completed the bath, emptied the basin of water and prepared to place a clean brief. NA #8 was questioned as to whether all of the stool had been removed from the vaginal area and she responded that she had cleaned the best she could as it was difficult to open Resident #65's legs. NA #8 commented that she had needed help to open her legs to adequately clean the perineal area. She did not leave the room to get assistance. NA #8 pushed Resident #65's thighs apart and began using several disposable wipes to remove stool that had been left inside the vaginal region and perineum. Once the stool was removed, she placed a clean brief.</p> <p>NA #8 was interviewed after the observation at 11:50 AM on 02/11/15. NA #8 stated she had been taught to have all of the needed supplies before beginning the bed bath. She stated she was to change her gloves each time after washing a new area of the body. NA #8 reported</p>	F 312			

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F 312	<p>Continued From page 6</p> <p>that she always started with the face and worked downward leaving the resident's buttocks/perineum for last. She commented that usually there was another nurse aide assisting her with opening Resident #65's legs so she could adequately cleanse her skin. NA #8 commented that leaving stool inside the vaginal area might cause a urinary tract infection if it wasn't removed adequately.</p> <p>During an interview with the Director of Nurses (DON), on 02/12/15 at 3:45 PM, he stated during personal care it was his expectation that staff wash every area of the resident's body. He stated they should be washing front to back to remove stool from the entire perineum. The DON stated staff should ask for additional help if it was difficult for them to open a resident's legs to adequately wash the perineum. The DON commented there was more than enough assistance available on Resident #65's hall to assist with holding one's legs apart for hygiene care.</p> <p>2. A review of the annual minimum data set (MDS) assessment dated 01/28/2015 revealed Resident #170 was admitted to the facility on 04/09/2015 with multiple diagnoses which included diabetes mellitus, benign prostatic hyperplasia, and Alzheimer's disease. The same assessment indicated that the resident was severely cognitively impaired and was totally dependent upon staff for bathing. In addition, the assessment indicated Resident #170 needed</p>	F 312			

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F 312	<p>Continued From page 7</p> <p>extensive assistance with toileting and personal hygiene.</p> <p>The resident's nursing care plan dated 01/30/2015 had a measurable goal with interventions to address his total dependence on staff for his bathing needs.</p> <p>An observation of a bath provided by nursing assistant (NA) #2 for Resident #170 was made on 02/11/2015 at 10:40 AM. As NA #2 prepared to bathe the resident, he applied a liberal amount of soap to the wash cloth and washed each section of the resident's upper body, including his face, ears, neck, chest, arms, hands, and back. After washing Resident #170's upper body with soap, NA #2 rinsed the washcloth out in the basin of water which contained a large amount of soap, then used the same washcloth to remove the soapy residue from his upper body. A large amount of soapy residue was still present after the nursing assistant used the washcloth to remove the soap from the resident. NA #2 then dried the resident's upper body with a towel. After NA #2 completed bathing for the upper section of the resident's body, he washed the groin and buttocks using the same technique, then applied a clean disposable brief. After NA #2 finished bathing the groin, upper thighs, and buttocks area, he began to dress the resident's lower body with slacks. NA #2 did not wash the resident's lower legs or feet.</p> <p>An interview was conducted with NA #2 during the bathing observation on 02/12/2015 at 10:40 AM. NA #2 stated that he was not going to bathe the resident's lower legs and feet. He explained that he only washed the lower legs and feet on days when he changed the resident's socks, and that he sometimes changed the socks about every third day, or sometimes more often. NA #2 stated this was the method he used for Resident</p>	F 312			

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F 312	<p>Continued From page 8</p> <p>#170's bath.</p> <p>A review of the directions documented on the bottle of body wash used for the resident revealed the soap should be rinsed off after bathing. In an interview with Nurse #1 on 02/11/2014 at 3:12 PM, she stated that it was her expectation that the nursing assistants should bathe the entire resident's body when bathing is provided, including the lower legs and feet. Nurse #1 added she did not know why NA #2 would not have washed these areas. Nurse #1 also stated that soap that needed rinsing should be rinsed with a clean moist washcloth before drying with a towel.</p> <p>In an interview with the Director of Nursing (DON) on 02/11/2015 at 3:20 PM, he stated that the resident's entire body should be bathed during a bed bath, and that soap which required rinsing should be rinsed with clean water. Per the Director of Nursing, the facility used Lippincott Procedures for bed bath guidelines.</p> <p>In an interview with the DON at 5:00 PM on 02/11/2015, he stated NA #2 was provided an in-service training regarding bed baths after he received the report that the nursing assistant failed to provide a complete bed bath. A copy of the in-service-education training report was provided which indicated the in-service took place at 3:30 PM on 02/11/2015, and that the topics included in the training included rinsing soap from the resident with clean water and removing socks to bath the feet and legs during the bath.</p> <p>A computer copy of the Lippincott Procedure Quick List for: Bed Bath (Copyright 2015, IP 96.10.23.26) was provided by the DON for review on 02/12/2015 at 5:40 PM. The review of the policy revealed instructions to bathe the entire body and stated in part, "Wash, rinse, and dry</p>	F 312			

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F 312	Continued From page 9 the patient's legs and feet; uncover one leg at a time."	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to provide the primary physician with culture and sensitivity results in order that he might make a decision about possible antibiotic treatment for 1 of 6 residents (Resident #29) reviewed for urinary tract infection (UTI) prevention and treatment. The facility also failed to collect a urine sample and initiate antibiotic treatment in parameters acceptable by the primary physician for of 1 of 6 residents (Resident #263) reviewed for UTI prevention and treatment. Findings included: 1. Resident #29 was admitted to the facility on 10/30/14. The resident's documented diagnoses included Alzheimer's disease, dementia with behaviors, and history of falls. A 11/22/14 nurse's note documented Resident	F 315	F 315 The facility will continue to strive to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident # 29 was assessed by attending physician on 3/2/14. The resident attending physician wrote for new orders at that time. The clinical managers (Director of Nursing and unit managers) reviewed each facility resident to ensure that any resident requiring UA had been collected and results were reviewed by attending	3/10/15	

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F 315	<p>Continued From page 10</p> <p>#29 was hallucinating and attempting to get out of bed unassisted. The primary physician recommended collecting urine for a urinalysis (UA).</p> <p>A 11/23/14 physician order started Resident #29 on Cipro 250 milligrams (mg) twice daily (BID) x seven days.</p> <p>On 11/25/14 Resident #29's primary physician initialed off on culture and sensitivity (C & S) lab results documenting there were greater than 100,000 colony-forming units (CFUs) of Escherichia coli bacteria grown in the urine specimen collected from Resident #29 on 11/23/14.</p> <p>A 12/06/14 Nursing Daily Skilled Summary documented Resident #29 was more confused and unable to answer simple questions on first and second shift. The nurse left a change of condition form for the primary physician questioning whether follow-up labs might need to be drawn to make sure the November antibiotic therapy was effective in treating the resident's UTI.</p> <p>12/07/14 preliminary UA results documented the presence of 2+ bacteria and elevated white blood cells. A staff member documented Resident #29 had just completed a seven-day course of Cipro antibiotic, but was continuing to experience increased confusion. The primary physician responded to follow-up with C & S results.</p> <p>12/09/14 final UA lab results/C & S documented greater than 100,000 CFUs of two bacteria in Resident #29's urine sample, Acinetobacter baumannii and Enterococcus faecalis, both of</p>	F 315	<p>physician on 3/04/15.</p> <p>The facility licensed nurses were provided re- education on documentation of new orders for UA. The documentation requires that the nurse place UA orders on a monitoring sheet to be kept on the nurses clipboard daily. The Unit Managers/Supervisor will review the monitoring sheets daily to assure that the ordered UAs have been collected and results followed up with the attending physician. Monitoring will occur daily.</p> <p>The DON or designee will complete a weekly UA audit tool to ensure timely collection, processing and physician follow up weekly times four and bi- monthly times one.</p> <p>The Director of Nursing will report findings of weekly audits to the facility quality improvement committee weekly times four weeks and then bi-monthly times one month. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Date of Completion 3/10/15</p>		

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PRINTED: 03/10/2015
FORM APPROVED
OMB NO. 0938-0391

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F 315	<p>Continued From page 11 which were resistant to the Cipro the resident completed in November. However, there were no physician initials on these result pages, thus no orders were generated.</p> <p>Nurse's notes documented continued escalation in behaviors with the resident pulling her catheter out on 12/09/14, the resident being found on the bathroom floor on 12/12/14, and refusal of care and swatting at staff on 12/13/14.</p> <p>A 12/19/14 physician order requested a UA, C & S be obtained for Resident #29 due to increased behaviors/agitation. Final lab/C & S results were initialed by the resident's primary physician, and results documented the resident had 45,000 CFU of Escherichia coli bacteria in her urine specimen. The physician opted not to treat with an antibiotic.</p> <p>At 9:25 AM on 02/12/15, during a telephone conversation, Resident #29's primary physician stated generally when there was 100,000 CFU of bacteria in urine "something was wrong." He reported he almost always treated this type of infection with an antibiotic if there were physical symptoms such as burning upon urination, frequent urination, and elevated temperature or if residents presented with newly emerging or worsening behaviors. According to the physician, he always initialed lab results and C & S results after reviewing them.</p> <p>At 4:00 PM on 02/12/14 the director of nursing (DON) stated lab and C & S results were placed in physician boxes in the facility. He explained doctors initialed them after review. If some results were not initialed off, the DON reported unit managers were expected to contact the physicians and share the results so decisions</p>	F 315			

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F 315	<p>Continued From page 12 could be made about possible treatment.</p> <p>At 4:22 PM on 02/12/14 Nurse #5, a unit manager, stated if he found lab results without initials he contacted physicians to make sure they were aware of outcomes.</p> <p>At 5:10 PM on 02/12/15 Resident #29's primary physician stated he expected the facility to call him when they did not find his initials on the resident's 12/09/14 final lab and C & S results. With greater than 100,000 CFU units of two different types of bacteria he explained he needed this information to decide whether further antibiotic treatment was necessary.</p> <p>2. Resident # 263 was admitted to the facility on 01/20/15. The resident's diagnoses included episodic mood disorder, dementia with behavioral disturbances, and depression.</p> <p>A 01/23/15 physician order requested a urinalysis (UA) and culture and sensitivity (C& S) for the resident due to urine with strong and foul odor.</p> <p>A 01/24/15 11 - 7 nurse's note documented the resident was very irate, trying to get out of her geri-chair and throw herself to the floor.</p> <p>A 01/25/14 2:45 PM note on the Nursing Daily Skilled Summary made by Nurse #3 documented, "...UA, C & S was ordered 01/23/15. Catheterized resident (in and out) to obtain UA, C & S. 650 cubic centimeters (cc) of dark amber urine was drained with foul odor and sedimentation. Specimen sent to _____ (name of hospital) stat....Resident is having auditory and visual hallucinations. Resident is combative at times. Attempts to get out of chair several</p>	F 315			

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F 315	<p>Continued From page 13 times...."</p> <p>A 01/25/14 11:30 PM note on the Nursing Daily Skilled Summary documented, "Obtained results of UA, MD (physician) called and given results...."</p> <p>A 01/26/15 physician order began Resident #263 on Cipro (antibiotic) 250 mg BID x 7 days.</p> <p>Review of the resident's January 2015 medication administration record (MAR) documented she did not receive her first dose of Cipro until 01/26/15 at 9:00 PM.</p> <p>At 4:02 PM on 02/12/15, during a telephone interview, Nurse #5 stated she worked on Saturday, 01/24/15, and Sunday, 01/25/15. She reported it was not shared with her by the out-going nurse on Saturday morning that a urine sample needed to be collected for Resident #263. This nurse commented the resident was extremely agitated over the weekend, and on Sunday afternoon a family member asked her what the outcome of the labwork was. It was at this time the nurse explained she began to do some research, and realized that a urine sample should have been collected for the resident on Friday or Saturday.</p> <p>Review of the 24-Hour/Change of Condition Report for 01/23/15 documented Resident #263 was due a UA, C & S to be drawn in the AM in two places. This notation appeared in a section on top of the report for the resident's hall and in the remarks section by the resident's actual name.</p> <p>At 10:02 AM on 02/12/15 the director of nursing (DON) stated he expected on-coming nurses to</p>	F 315			

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F 315	Continued From page 14 listen to the report given by out-going nurses, but he also expected the on-coming nurses to review the 24-Hour/Change of Condition Report periodically. The DON reported unless residents were combative he expected urine to be collected on the same day as the order was received for the UA, and at the very latest the urine be collected early the next day. He stated a resident having an order for a UA on 01/23/15 and not having the urine collected until 2:45 PM on 01/25/15 and not receiving antibiotic treatment until the night of 01/26/15 when the lab results were available on 01/25/15 at 11:30 PM was not acceptable.	F 315			
F 329 SS=D	At 5:10 PM on 02/12/15 Resident #29's primary physician stated be expected urine to be collected for residents on the day of or early the next day after an order for a UA was received. 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		3/10/15	

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F 329	<p>Continued From page 15 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, physician interview, consultant pharmacist interview, staff interview, and record review the facility failed to attempt alternate management of behaviors associated with urinary tract infections (UTIs) before placing 2 of 5 residents (Resident #29 and #263) reviewed for unnecessary medications on scheduled antipsychotic medications. The facility also failed to attempt gradual dose reductions of these antipsychotics after treatment of the UTIs was completed. Findings included:</p> <p>1. A 10/30/14 hospital Discharge Summary documented Resident #29 was hospitalized from 10/26/14 through 10/30/14. No antipsychotics were listed under home medications. However, the summary documented the resident had an order for as needed (PRN) hypnotics and PRN intravenous (IV) Haldol 2.5 milligrams every four hours.</p> <p>Resident #29 was admitted to the facility on 10/30/14. The resident's documented diagnoses included Alzheimer's disease, dementia with behaviors, history of falls, and femur fracture. The resident was not admitted on any anti-anxiety or antipsychotic medications.</p>	F 329	<p>F 329</p> <p>The facility will continue to strive to ensure that each resident's medication regimen must be free from unnecessary drugs.</p> <p>Resident # 29 medication regimen was reviewed by attending physician on 3/2/15. The attending physician ordered that resident continue current medication regimen until appointment with psychiatry on March 19, 2015.</p> <p>The facility residents identified with antipsychotic medication were reviewed by Director of Nursing and Assistant Director of Nursing on 3/04/15 for appropriateness and possibility of medication reductions. The attending physicians were contacted if indicated during review for further evaluation and new orders if indicated.</p> <p>Licensed Nursing staff were in-serviced on the care path to follow for Mental Status Changes and Urinary tract Infections. The facility newly hired</p>		

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F 329	<p>Continued From page 16</p> <p>The resident's 11/06/14 admission minimum data set (MDS) documented her cognition was moderately impaired, she exhibited no psychosis or behaviors, she did not reject care, and she was on no psychotropic medications.</p> <p>A 11/22/14 nurse's note documented Resident #29 was hallucinating and attempting to get out of bed unassisted. The primary physician recommended collecting urine for a urinalysis (UA).</p> <p>A 11/23/14 physician order started Resident #29 on Cipro 250 mg twice daily (BID) x seven days.</p> <p>A 11/24/14 physician order placed Resident #29 on Haldol (antipsychotic) 1 mg BID and PRN Ativan 0.5 mg every six hours.</p> <p>A 11/24/14 psychiatric consult documented, "...referred for psychiatric evaluation regarding stabilization of confused, disorganized thinking and combative behavior. Nursing staff indicate that on 11/24 resident became increasingly combative. I see that she started antibiotics the day prior to this for UTI. Resident has been living in this facility since the end of October with no previous reports of combativeness or agitation....Feels that behavior reflects delirium from underlying infection and should resolve once infection is completely eradicated. PCP (primary care physician) started scheduled Haldol on 11/24 in response to these behaviors....Will continue this medication for now, however, feel this can eventually be tapered and discontinued as she has no history of previous psychosis prior to this incident. Feel that resident would benefit from addition of cognitive agent to preserve cognitive</p>	F 329	<p>licensed nurses will receive education regarding during orientation.</p> <p>DON and/or clinical managers will review new orders daily times thirty days and bi <input type="checkbox"/> monthly , for new antipsychotic prescriptions or changes to existing orders to ensure proper care path has been followed to rule out other medical conditions and ensure appropriate medication regimen. Reviews will be documented on an antipsychotic monitoring tool to be reviewed by clinical team weekly.</p> <p>The Director of Nursing will report findings of weekly audits to the facility quality improvement committee weekly times four weeks and then bi-monthly times one month. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Date of Completion 3/10/15</p>		

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F 329	<p>Continued From page 17</p> <p>function and perhaps improve dementia related behavior in the future. Will initiate Exelon patch today and continue to monitor her as needed."</p> <p>On 11/25/14 Resident #29's primary physician initialed off on final UA lab results/culture and sensitivity (C & S) documenting there were greater than 100,000 colony-forming units (CFUs) of Escherichia coli bacteria grown in the urine specimen collected from Resident #29 on 11/23/14.</p> <p>A 12/06/14 Nursing Daily Skilled Summary documented Resident #29 was more confused and unable to answer simple questions on first and second shift. The nurse left a change of condition form for the primary physician questioning whether follow-up labs might need to be drawn to make sure the November antibiotic therapy was effective in treating the resident's UTI.</p> <p>12/09/14 final UA lab results/C & S documented greater than 100,000 CFUs of two bacteria in Resident #29's urine sample, Acinetobacter baumannii and Enterococcus faecalis, both of which were resistant to the Cipro the resident completed in November. However, there were no physician initials on these result pages, thus no orders were generated.</p> <p>Nurse's notes documented continued escalation in behaviors with the resident pulling her catheter out on 12/09/14, the resident being found on the bathroom floor on 12/12/14, and refusal of care and swatting at staff on 12/13/14.</p> <p>A 12/15/14 physician order added Seroquel (antipsychotic) 12.5 mg nightly to the resident's</p>	F 329			

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F 329	<p>Continued From page 18 medication regimen, and requested a follow-up psychiatric evaluation.</p> <p>The 2014 edition of Lexi-Comp's Drug Information Handbook for Nursing documented side effects of Seroquel included hypotension, especially upon initiation, and dizziness.</p> <p>On 12/15/14 care plans for psychoactive medications and behavior symptoms were developed for Resident #29. The medication care plan documented the resident required the administration of an antipsychotic due to psychosis and anxiety indicated by disorganized thinking and combative behaviors. Approaches to this problem included "Periodic reviews of medications by interdisciplinary team to determine potential dose reductions" and "Observe for potential side effects of medication administered". The behaviors care plan documented the resident exhibited physical abuse and resisted care with target behaviors including combativeness and refusing medications, care, and blood sugars. Approaches to this problem included "Modify environment, situations, and/or treatment to minimize external stressors".</p> <p>Interdisciplinary Post Fall Reviews documented Resident #29 had falls on 12/16/14 at 7:30 PM, 12/16/14 at 11:30 PM, and 12/17/14 at 6:45 AM. None of the falls resulted in injury.</p> <p>A 12/17/14 clarification order documented Haldol was being used to treat Resident #29's combativeness with staff and refusal of care. The diagnosis justifying the use of the resident's Haldol was dementia with behaviors.</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>A 12/17/14 urology consult documented the resident's indwelling catheter could be removed since the urinary retention was resolved and the femur fracture was healing well.</p> <p>Interdisciplinary Post Fall Reviews documented Resident #29 fell on 12/19/14 at 12:20 PM and 12/21/14 at 6:00 PM.</p> <p>A 12/30/14 psychiatric follow-up assessment documented, "Resting in bed today in no acute distress. Continues to seem quite confused on approach but has tolerated initiation of Seroquel by PCP on 12/15 without incident. PCP previously initiated scheduled Haldol on 11/24 for delusional agitation that was likely associated with underlying infection that was being treated at the time. Typically, use of two different antipsychotic agents does not yield more efficacious results than maximizing a single agent, however, she seems to be tolerating these medications well so far....Continues to be combative with care at times and has had several falls recently, which is likely related to her confusion...." This psychiatric service referred further care for the resident out to an outpatient psychiatric service. (see 02/12/15 3:52 PM interview with scheduler--appointment with outpatient psychiatric services was cancelled due to family wishes to continue in-house service)</p> <p>The resident's 01/26/15 quarterly MDS documented her cognition was severely impaired, she exhibited no psychosis or behaviors, she rejected care 1 - 3 days during the assessment period, and she received antipsychotic medications for 7 of 7 of the last days and an anti-anxiety medication for 1 of 7 of the last days.</p>	F 329			

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F 329	<p>Continued From page 20</p> <p>A 02/01/15 consultant pharmacist recommendation documented Resident #29 was receiving both Haldol and Seroquel "without supporting documentation...Neither agent is especially efficacious in treating agitation in dementia. Please re-evaluate the need for both and agents and provide appropriate documentation." The undated staff response documented outpatient psychiatric services were being set up for the resident. Resident #29 continued to remain on both the Haldol and Seroquel.</p> <p>A 02/09/15 behavior care plan update documented, "Behaviors improved after (symbol used) treatment for UTI. Continue to redirect PRN and provide emotional support."</p> <p>At 10:10 AM on 02/11/15 a treatment observation was completed for Resident #29. The resident was calm, talkative, and cooperative throughout the treatment.</p> <p>At 1:45 PM on 02/11/15 nursing assistant (NA) #5, who cared for Resident #29 on first shift, stated the resident had very few behaviors when she was first admitted, but things changed when the resident was diagnosed with a UTI. She reported during and shortly after the UTI the resident would swing and hit at the staff, yell out, and attempt to get out of bed and her chair without assistance. According to this NA, the resident's behaviors had stabilized again in the last month, and the resident was a lot more calm.</p> <p>At 1:54 PM on 02/11/15 Nurse #2, who cared for Resident #29 on first shift, stated about a month after admission the resident began resisting care, striking out at the staff, and getting up unassisted.</p>	F 329			

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F 329	<p>Continued From page 21</p> <p>She stated most of the behaviors were resolved when the resident had her indwelling catheter removed (on 12/17/14).</p> <p>At 3:53 PM on 02/11/14 Resident #29 was sitting in her room. She was calm, and did not exhibit any behaviors.</p> <p>At 4:27 PM on 02/11/15 NA #6, who cared for Resident #29 on second shift, stated at one time the resident had some hallucinations, wandered into other resident's rooms, resisted care, and attempted to get up unassisted. She reported most of this resolved in the last month, and the resident was cooperative as long as you spoke loudly into the resident's ears and told her what care needed to be provided in advance.</p> <p>At 4:42 PM on 02/11/15 Nurse #4, who cared for Resident #29 on second shift, stated about a month after admission the resident became combative, yelled out, and got up unassisted. However, she reported the resident's behaviors had lessened dramatically in the past month.</p> <p>At 6:45 PM on 02/11/15 the facility's consultant pharmacist stated the primary focus should be treating the UTI with antibiotic therapy when behaviors emerged due to the infection. However, he commented there were times when managing the behaviors with anti-anxiety and antipsychotic medications was necessary. According the pharmacist, antipsychotic medications should only be utilized when behaviors emerging from UTIs placed the sick residents in imminent danger or other residents around them in imminent danger. He reported if antipsychotic medications had to be used then the dosage should be tapered after the UTI was resolved,</p>	F 329			

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

PRINTED: 03/10/2015
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 22 and depending on the results of the tapers, should be discontinued gradually if possible.</p> <p>At 9:25 AM on 02/12/15, during a telephone conversation, Resident #29's primary physician stated if residents' had psychiatric diagnoses he sometimes prescribed low doses of antipsychotic medications to help manage behaviors associated with UTIs. He reported he liked to follow the antipsychotic initiation with psychiatric consults. He also commented he liked to refer to psychiatric providers when making decisions if and when to taper or discontinue antipsychotic medications. The MD remarked he had not had a lot of success using anti-anxiety medications for treating behaviors emerging from UTIs.</p> <p>At 10:18 AM on 02/12/14 Resident #29 was lying across her bed. The resident was calm, and did not exhibit any behaviors.</p> <p>At 3:52 PM on 02/12/15 the facility's scheduler stated she thought Resident #29's appointment with outpatient psychiatric services was cancelled because the resident's family preferred the resident to continue to see in-house psychiatric services.</p> <p>At 3:58 PM on 02/12/15 Resident #29 was sitting in her room conversing with her roommate. The resident did not present with any behaviors.</p> <p>At 5:10 PM on 02/12/15 Resident #29's primary physician stated he knew Resident #29 from another facility, and she had many behaviors there. He reported the resident had a diagnosis of dementia with behavioral problems. According to the MD, when he assessed the resident in her current facility she was very agitated, trying to get</p>	F 329			

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F 329	<p>Continued From page 23</p> <p>out of her chair unassisted, not eating, throwing things, and hitting staff. He stated he started the resident on Haldol for psychosis management. The MD reported he initiated the use of Seroquel for the resident because the Haldol alone did not seem to be effective in controlling an escalation in behaviors.</p> <p>2. A 01/20/15 hospital Discharge Summary documented resident #263 was hospitalized between 01/18/15 and 01/20/15 for a left ischium fracture. No antipsychotic medications were listed under home medications, and the resident received no scheduled antipsychotics while hospitalized.</p> <p>Resident # 263 was admitted to the facility on 01/20/15. The resident's diagnoses included episodic mood disorder, dementia with behavioral disturbances, depression, left ischium fracture, and difficulty walking. The resident was not admitted to the facility on any antipsychotic medications.</p> <p>A 01/21/15 physician order started Resident #263 on Seroquel (antipsychotic) 25 milligrams (mg) every night and as needed (PRN) Xanax 0.25 mg every eight hours.</p> <p>A 01/22/15 physician order requested a psychiatric consult for the resident.</p> <p>A 01/23/15 physician order requested a urinalysis (UA) and culture and sensitivity (C& S) for the resident due to urine with strong and foul odor.</p> <p>A 01/23/15 psychiatric consult documented, "referred for psychiatric evaluation regarding stabilization of confused, disorganized thinking</p>	F 329			

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F 329	<p>Continued From page 24</p> <p>and depression versus adjustment. Was able to interview resident briefly today...She was pleasant and seemed confused but had no obvious signs or symptoms of depression, anxiety, mania, or psychosis. Was admitted to facility 01/20/15 following hospitalization for hip fracture and also has a documented history of bipolar disorder (documented diagnosis was episodic mood disorder) and depression. Came to facility taking combination of Zoloft and Seroquel (was placed on the combination by the primary physician after the resident entered the facility on 01/20/15--medications ordered 01/21/15) presumably for bipolar disorder and seems to be tolerating these medications without any adverse reactions or side effects....Nursing staff did not verbalize any specific complaints to me in her regard today. However, roommate does indicate that resident often keeps her awake at night as she becomes more confused and "talking out of her head." Since resident was only recently admitted to facility, I would like to give her some time to adjust and settle in before attempting to change medication regimen...." Diagnoses based on the consult were unspecified episodic mood disorder, dementia with behaviors, anxiety, depression, and adjustment reaction.</p> <p>A 01/23/15 11:10 PM nurse's note documented Resident #263 was trying to get out of her geri-chair without assistance. When the staff attempted to assist the resident she became combative and threatened the staff. The resident stated she needed to go to the bathroom, but when staff tried to take her, she started fighting and crying.</p> <p>A 01/24/15 Nursing Daily Skilled Summary documented Resident #263 was sitting up in the</p>	F 329			

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F 329	<p>Continued From page 25 hallway trying to get out of her chair, and was very difficult to redirect. The resident refused her breakfast and lunch meals.</p> <p>A 01/24/15 11 - 7 nurse's note documented the resident was very irate, trying to get out of her geri-chair and throw herself to the floor. PRN Xanax was administered.</p> <p>A 01/25/14 2:45 PM note on the Nursing Daily Skilled Summary documented, "...UA, C & S was ordered 01/23/15. Catheterized resident (in and out) to obtain UA, C & S. 650 cubic centimeters (cc) of dark amber urine was drained with foul odor and sedimentation. Specimen sent to _____ (name of hospital) stat. Resident seems a little less restless after draining bladder. Resident is having auditory and visual hallucinations. Resident is combative at times. Attempts to get out of chair several times...."</p> <p>A 01/25/14 11:30 PM note on the Nursing Daily Skilled Summary documented, "Obtained results of UA, MD (physician) called and given results...."</p> <p>A 01/25/15 physician order discontinued Resident #263's Seroquel and began Haldol (antipsychotic) 0.5 mg twice daily (BID).</p> <p>A 01/26/15 physician order began the resident on Cipro (antibiotic) 250 mg BID x 7 days. The order also started the resident on Restoril 15 mg every night.</p> <p>The resident's 01/26/15 admission minimum data set (MDS) documented the resident's cognition was severely impaired, she presented with no indicators of psychosis, she exhibited physical and verbal behavioral symptoms, she rejected</p>	F 329			

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F 329	<p>Continued From page 26</p> <p>care, and she received seven days of antipsychotic medications and three days of anti-anxiety medication during the lookback period.</p> <p>The Behavioral Symptoms Care Area Assessment (CAA) generated by the 01/26/15 MDS documented, "_____ (name of resident) has also displayed behaviors, such as hitting at staff, crying, aggression towards staff and family, and refusing to eat breakfast and lunch on 1/24. She has been seen by psych nursing consultant on 1/26. She has also attempted self transfers...She was admitted here with hx (history) of dementia and mood disorder. Psych consult resulted in additional diagnoses including dementia with behaviors, anxiety, depression, and adjustment reaction. She is obviously a new admission with environment and all caregivers being new to her."</p> <p>A 01/28/15 Change of Condition form documented at 3:00 AM resident was very agitated, hitting at staff and wheelchair. The resident was banging her hand of the armrests of her chair and shaking the footrests. A family member was called to sit with the resident in hopes of calming her down. The resident stated, "Shoot me." Xanax was administered.</p> <p>On 01/29/15 Resident #263 was care planned for behavioral symptoms (verbal and physical abuse, socially inappropriate behavior, and resistance of care). Approaches to this problem included modifying the environment, situations, and/or treatment to minimize external stressors.</p> <p>A 01/30/15 psychiatric follow-up consult documented, "Resident is up and out today in no acute distress. Staff report that resident having</p>	F 329			

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F 329	<p>Continued From page 27</p> <p>periods of increased agitation and combative behavior that are worse at night. Since my last visit, resident has been diagnosed with UTI and is on antibiotics. Feel that recent mental status and behavior changes are likely associated with delirium from underlying infection. PCP (primary care physician) has discontinued Seroquel in favor of starting Haldol instead for psychosis with agitation. She seems to have tolerated switch well so far without any adverse reactions or side effects. Also noted to have started Restoril for insomnia on 1/28 and staff report that this medication is helpful. Has required PRN Xanax for acute episodes of anxiety/agitation four time so far this months....Feel that agitation and confusion should improve with treatment of underlying infection, but will continue to monitor closely." Diagnoses documented from this assessment included delirium due to conditions classified elsewhere, dementia with behaviors, psychosis, and anxiety.</p> <p>02/01/15 recommendations from the facility's consultant pharmacist documented the resident was receiving Haldol without "specific target behavior(s) identified as acceptable by CMS (Centers for Medicare and Medicaid Services) regulations. A staff member documented, "Discharge". The pharmacist also warned with the resident on Haldol, "Symptoms or behaviors MUST present a DANGER to the resident or others AND one or both of the following symptom criteria: a) the symptoms are due to mania or psychosis OR b) care-planned behavioral interventions have been attempted, except in an emergency." The primary physician replied, "Psych F/U (follow-up)".</p> <p>Review of Resident #263's medical record</p>	F 329			

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F 329	<p>Continued From page 28</p> <p>revealed no behavior tracking sheets were being kept.</p> <p>A 02/02//15 11 - 7 nurse's note documented the resident was awake all night and very aggressive toward staff. She would not let the NA bathe her, and she was hitting at staff.</p> <p>A 02/04/15 nurse's note documented the resident was restless, confused, and cried at times.</p> <p>On 02/05/15 Resident #263 was care planned for the use of anti-anxiety and antipsychotic medications. Approaches included "Periodic review of medications by interdisciplinary team to determine potential dose reductions", "Observe for potential side effects of medication administered", and "Observe for medication effectiveness and document via flow checklists".</p> <p>A 02/06/15 physician order requested another psychiatric consult for Resident #263 (record review this was not accomplished, and the resident was discharged home on 02/10/15).</p> <p>At 4:18 PM on 02/09/15 Resident #263 was sitting in her room. The resident was calm and without behaviors.</p> <p>At 10:16 AM on 02/10/14 Resident #263 was out in the hallway talking to the nurse. She was calm and without behaviors.</p> <p>At 10:25 AM on 02/10/15 a family member stated Resident #263 was being discharge home. The family member reported the resident did not have a history of psychiatric illness, and had never taken antipsychotic medications at home.</p>	F 329			

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F 329	<p>Continued From page 29</p> <p>At 1:45 PM on 02/11/15 nursing assistant (NA) #5, who cared for Resident #263 on first shift, stated the resident tried to fight staff, yelled out, and tried to get up unassisted. However, in the last week the NA reported the resident "was a different woman" with much less anxiety and very few behaviors.</p> <p>At 1:54 PM on 02/11/15 Nurse #2, who cared for Resident #263 on first shift, stated the resident was combative with staff, resisted some care, and tried to get up unassisted. She remarked the resident's behaviors might have lessened some in the last week.</p> <p>A 4:33 PM on 02/11/15 NA #7, who cared for Resident #263 on second shift, stated the resident yelled out in the past and got up unassisted, but since the resident's behaviors had lessened, she was being allowed to go home.</p> <p>At 4:42 PM on 02/11/14 Nurse #4, who cared for Resident #263 on second shift, stated the resident had intermittent episodes when she was combative with staff, verbally abusive, and got up unassisted. She commented she thought the resident behaved better in the last week.</p> <p>At 6:45 PM on 02/11/15 the facility's consultant pharmacist stated the primary focus should be treating the UTI with antibiotic therapy when behaviors emerged due to the infection. However, he commented there were times when managing the behaviors with anti-anxiety and antipsychotic medications was necessary. According the pharmacist, antipsychotic medications should only be utilized when behaviors emerging from UTIs placed the sick residents in imminent</p>	F 329			

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F 329	<p>Continued From page 30</p> <p>danger or other residents around them in imminent danger. He reported if antipsychotic medications had to be used then the dosage should be tapered after the UTI was resolved, and depending on the results of the tapers, should be discontinued gradually if possible.</p> <p>At 9:08 AM on 02/12/15 Nurse #5 (a unit manager) stated in conversation with the contracted psychiatric service they stated in their 01/23/15 consult they documented Resident #263 suffered from bipolar disorder based on an ICD (international classification of diseases) code for episodic mood disorder.</p> <p>At 9:25 AM on 02/12/15, during a telephone conversation, Resident #263's primary physician stated if residents' had psychiatric diagnoses he sometimes prescribed low doses of antipsychotic medications to help manage behaviors associated with UTIs. He reported he liked to follow the antipsychotic initiation with psychiatric consults. He also commented he liked to refer to psychiatric providers when making decisions if and when to taper or discontinue antipsychotic medications. The MD remarked he had not had a lot of success using anti-anxiety medications for treating behaviors emerging from UTIs.</p> <p>At 5:10 PM on 02/12/15 Resident #263's primary physician stated the resident had diagnoses of depression, dementia with behaviors, and mood disorder. He reported during his assessment he thought the resident was suffering from psychosis so he prescribed Seroquel. He reported since the resident was still having behaviors later in her stay, he felt the Seroquel was not effective. Therefore, he explained he discontinued the Seroquel, and started the resident on Haldol.</p>	F 329			

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F 356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to post staffing on a daily basis and failed to revise staff posting when staff members called out and were not replaced.</p>	F 356	<p>F 356</p> <p>The facility will continue to strive to be in compliance with the daily staffing</p>	3/10/15	

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F 356	<p>Continued From page 32</p> <p>Findings included:</p> <p>At 5:13 PM on 02/08/15 (Sunday), during initial tour of the facility, the staffing sheet which was posted across from the main nurse's station was dated 02/06/15 (Friday).</p> <p>At 4:48 AM on 02/11/15 the staff posting documented there should be four nurses and seven nursing assistants (NAs) working in the facility at that time. Tour of the facility revealed there were only six NAs working.</p> <p>At 6:12 AM on 02/11/15 Nurse #8 stated she did not have the title of charge nurse or unit supervisor, but she was the nurse working third shift that had worked in the facility the longest. Therefore, she reported a lot of the third shift staff came to her with questions and problems. The nurse stated the second shift supervisor did not tell her about a call out, and she did not learn about the problem until about 1:00 AM. According to Nurse #8 , the NA who called out was not able to be replaced.</p> <p>At 7:50 AM on 02/11/15 the director of nursing (DON) stated the evening (second shift) supervisor (Nurse #6) should have revised the staff posting for third shift before she left the facility on 02/10/15 to reflect the call out. He reported it was also Nurse #6's responsibility to let the other nurses know about the call out and whether the staff member was able to be replaced or not. The DON also commented there was no third shift supervisor. According to the DON, the weekend supervisor (Nurse #7) was responsible for posting staffing sheets on the weekends.</p>	F 356	<p>postings. The staff posting sheet has been revised to reflect all licensed personnel responsible for direct patient care and facility name.</p> <p>On 2/7/15 and 2/8/15 the staff posting was reviewed to ensure that the numbers were correct by schedule coordinator. On 2/11/15 an addendum was added to the staff posting sheet to reflect all direct care staff to include medication aides.</p> <p>On 2/11/15 the staffing coordinator and all supervisors were in-serviced on proper completion of the revised daily staffing sheet by the Director of Nursing.</p> <p>On 3/6/15 the staffing coordinator reviewed the last thirty days of staff posting sheets to ensure that they reflected accurate staffing.</p> <p>The Director of Nursing or designee (unit manager, unit coordinator or supervisor) will observe for compliance with the daily staff posting and correct as necessary. The Director of Nursing will monitor using daily staffing sheet monitoring tool for any patterns in the failure to post, use of correct staff posting sheet and ensure all direct care staff are reflected for thirty days and then as deemed necessary by findings.</p> <p>The Director of Nursing will report findings of daily staff posting sheet audits to facility quality improvement committee weekly for four weeks and then bimonthly for one month. The committee will evaluate the</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/12/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(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 356	<p>Continued From page 33</p> <p>At 2:40 PM on 02/12/15 Nurse #6 (second shift supervisor) stated a staff member called out on third shift on 02/10/15. She explained the call out was at the last minute, and she was unable to get anyone else to replace the staff member. The nurse reported she was supposed to revise the staff posting sheet before she left work on 02/10/15, but is was extremely hectic, and she forgot to do so. She also commented she did not have time to inform other on-coming staff of the change in staff coverage on third shift.</p> <p>At 4:38 PM on 02/12/14 Nurse #7 (the weekend supervisor) stated she was aware that she was responsible for posting staffing sheets on the weekend. She reported she found the staffing sheet for 02/07/14 mixed in with some of her other paperwork, and it was so busy on 02/08/14 that she forgot about posting the staffing sheet.</p>	F 356	<p>results and implement additional interventions as needed to ensure continued compliance.</p> <p>Date of Completion 3/10/15</p>		