STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a plan of care for the treatment and care of a surgical wound for 1 of 3 sampled residents (Resident #2) reviewed with surgical wounds and failed to care plan an indwelling urinary catheter for 1 of 3 sampled residents (Resident #10) reviewed for catheters. Findings included: Resident #2 was admitted on 1/13/15 with a diagnosis of a laminectomy secondary to severe cervical stenosis. Review of the 1/13/15 Nursing Admission Intake Form documented Resident #2 had a cervical	F 279	F279 Develop Comprehensive Care Plans Resident #2: This resident was discharged from facility on February 20, 2015. Resident #10: An in-dwelling catheter care plan was initiated on March 12, 2015. The care plan had been misfiled so it was not available to present to the survey team before the time they exited. The care plan was reviewed April 1, 2015, and it was placed in resident□s medical record by the Divisional Director of Clinical Nursing.	4/3/15

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

Electronically Signed | 04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 279	Continued From page 1 collar worn due to recent surgery. The resident's care plan, reviewed on 1/16/16/15 and 1/27/15 did not address the surgical incision. An interview was held with the Minimum Data Set (MDS) nurse at 3/19/15 at 10:17 AM. The MDS nurse stated she care planned residents with multiple wounds, pressure ulcers receiving treatments and surgical wounds. Prior to development of the comprehensive care plan, wounds are included on the interim care plan. Goals and interventions included for the wound would be measurable goals developed for the wound. The MDS nurse stated the surgical wound was not identified on the care plan because she was unaware the surgical wound was still present with sutures at the time of care plan development, because the wound, dressings for the wound or suture removal was not listed in the Treatment Administration Record.. 2. Resident #10 was admitted on 2/23/15. Diagnoses included cerebral vascular accident, dementia, diabetes, hypertension, right flank/hip wound, unstageable foot wound, and contractures. The most recent Minimum Data Set (MDS), an Admission 5 day assessment, dated 3/2/15, indicated Resident #10 had an indwelling urinary catheter. A record review was conducted to include Resident ' s physician ' s orders. Further review revealed a telephone order written on 2/26/15 indicated the diagnosis for catheter was multiple wounds to include an unstageable wound to the foot and contractures.	F 279	On April 1, 2015, the facility interdisciplinary team consisting of the Minimum Data Set (MDS) nurses , Director of Nursing and the Assistant Director of Nursing reviewed each of the residents that had been identified with surgical wounds and in-dwelling catheters. The review was completed in order to ensure that each identified residents comprehensive care plan had been developed and that it included measurable objectives and timetables to meet each respective resident s ongoing medical, nursing, mental, and psychosocial needs. The facility Minimum Data Set (MDS) nurses were provided education regarding the development of residents comprehensive care plans reflecting the needs identified in the comprehensive assessment. The education was completed on April 1, 2015 by the District Resident Care Manager. The facility Administrator and the members of the Interdisciplinary Team that routinely make entries into the care plans (the Rehab Director, Social Worker, Dietary Director, Activities Director, Director of Nursing, Assistant Director of Nursing, and the Unit Coordinator) were provided education regarding the development of residents comprehensive care plans reflecting the needs identified in the comprehensive assessment. The education was completed on April 2, 2015 by the District Resident Care Manager. The members of the Interdisciplinary team that consists of the Director of Nursing, Assistant Director of Nursing and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 279	Continued From page 2 A record review of care plans for Resident #10 revealed that there was no care plan in place for the indwelling urinary catheter. An interview was conducted with the Minimum Data Set (MDS) Nurse on 3/19/15 at 3:34PM. While reviewing Resident #10 's chart with the nurse she confirmed there was no care plan in place for an indwelling urinary catheter. The MDS nurse reported the care plans should be placed within 3 weeks of admission. When interviewed as to why the care plan for the indwelling urinary catheter was not included, the MDS nurse stated she " missed it " .	F 279	Minimum Data Set (MDS) nurses will review two sampled residents comprehensive care plans to ensure their respective comprehensive care plans include measureable objectives and timetables to meet the resident s medical, nursing and mental and psychosocial needs. This will be completed weekly times four and bi-monthly times one. The results of the review will be documented on the Brain Center Windsor Care Plan Review form. The Facility Administrator will report findings of the MDS audits to the Quality Improvement Performance Committee weekly times four and monthly thereafter. Any negative findings or trends will be addressed. Interventions will be implemented as recommended by QAPI committee with ongoing evaluation of effectiveness.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to transcribe orders for removal of surgical sutures	F 309	F309 Provide Care/Services for Highest Well Being Resident #2: This resident was	4/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 3 and failed to remove the sutures for 1 of 3 sampled residents (Resident #2) and failed to complete treatment to a surgical wound as ordered by the physician for 1 of 3 sampled residents (Resident #5) reviewed for surgical wound care. Findings included: 1. Resident #2 was admitted on 1/13/15 with status post laminectomy due to cervical stenosis with cervical myelopathy. The Hospital Discharge Summary, dated 1/13/15, indicated Resident #2 had a decompressive laminectomy. Discharge instructions included orders to remove the surgical sutures at the skilled nursing facility on 1/19/15 with a follow up Neurosurgery on 2/18/15. Review of the 1/13/15 Nursing Admission Intake Form documented Resident #2 had a cervical collar worn due to recent surgery. There was no documentation of the presence of sutures. Facility Admission orders, written on 1/13/15 did not include orders for removal of the sutures on 1/19/15. The orders had been signed as transcribed by Nurse #1. There was no signature from a second nurse to identify the orders had been reviewed for accuracy. The 2/5/15 Admission Minimum Data Set (MDS) indicated the resident was cognitively intact with no behaviors or rejection of care. The surgical wound was identified on the MDS. The resident's care plan, reviewed on 1/16/16/15 and 1/27/15 did not address the surgical incision. The January 2015 Treatment Record (TAR) was not in Resident #2's medical record and was not located by facility staff. Reviewed of the February 2015 TAR failed to reveal an entry for removal of Resident #2's	F 309	discharged from facility on February 20, 2015. Resident #5: The treatment orders regarding surgical wounds on left, lower, medial, and lateral extremity were reviewed. The original order said to treat twice a day. A physician order was obtained on March 24, 2015 to cleanse left, lower, medial, and lateral extremity with normal saline, apply wet to dry dressing, and wrap with Kerlix and ace bandage daily rather than twice a day. Physician orders for newly admitted residents for the past thirty days were reviewed to ensure that physician orders were transcribed correctly and that the orders were being effectively carried out. The review was completed by the Director of Nursing and Assistant Director of Nursing on April 3, 2015. On April 3, 2015, the facility licensed staff were provided education regarding the review of discharge orders and the transcribing of physician orders. Education will be complete on April 6, 2015. Any licensed staff not available to receive education between April 3, 2015 and April 6, 2015 will be educated prior to working in a licensed capacity. Newly hired licensed staff will be provided the education during orientation. The Director of Nursing and/or Assistant Director of Nursing will review all physician orders to ensure that the orders have been transcribed correctly and that they are being carried out times sixty days. The designated nurse reviewing the orders will indicate the review has been completed and verify the review by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 4 sutures. Review of nurse's notes failed to document the removal of Resident #2's surgical sutures on 1/19/15 as ordered by the physician. The physician documented on a Neurology Consultation, dated 2/19/15, that the sutures had not been removed by the nursing facility as the instructions had been forwarded. The physician added at the time Resident #2 left the hospital, the sutures were supposed to be removed as instructed on 1/19/15. An interview was held with the MDS nurse at 3/19/15 at 10:17 AM. The MDS nurse stated she remembered the resident. The nurse added orders to remove the sutures on 1/19/15 had been included in the hospital discharge summary, but she knew the sutures had not been removed. She had no idea why the sutures were not removed. The MDS nurse stated she went by the treatment sheet to determine what wounds to care plan. She added on review of the January 2015 Treatment Record, Resident #2's surgical wound and removal of the sutures had not been added; therefore, she had not care planned the surgical wound or removal of the sutures. The MDS nurse added after the neurology consultation in February 2015, the resident's family verbalized concerns that the sutures had not been removed. She stated she reviewed the January 2015 treatment sheet and the removal of the sutures had not been added to the treatment sheet. A telephone interview was held with Nurse #4 on 3/19/15 at 10:50 AM. Nurse #4's signature was on Resident #2's admission orders as the nurse	F 309	initialing the top right corner of the order. The Director of Nursing will report findings of the Physician Order Audits to the Quality Improvement Performance Committee weekly times four and monthly thereafter. Any negative findings or trends will be addressed. Interventions will be implemented as recommended by QAPI committee with ongoing evaluation of effectiveness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 5	F 309		

that had transcribed the orders. Nurse #4 stated sometimes helped other nurses by transcribing admission orders. She added admission orders were taken from the hospital discharge summary. Nurse #4 stated the facility's policy was to have one nurse transcribe the admission orders and then a second nurse would check for accuracy and sign the Medication Administration Record (MAR) to indicate the second check had been completed. Nurse #4 stated she did not remember transcribing the admission orders for Resident #2, but if her signature was on the bottom, then she had transcribed the orders. The nurse provided no reason why another nurse had not double checked the admission orders. Nurse #4 could not remember removal of sutures being on the discharge orders and could not remember if she added the removal to the Treatment Administration Record (TAR). The nurse stated no one at the facility had notified her about the transcription error and she had not been notified Resident #2's sutures were not removed. The nurse stated there had been multiple in-services, but she could not remember when or exactly what the in-services addressed. In-services, she stated, usually consisted of a packet of papers left at the nurse's station for each nurse to review and sign or the Director of Nursing (DON) and/or the Administrator brought in-services to the nurses, ask the nurse to read and sign indicating the in-service had been read.

A telephone interview with a family member was held on 3/19/15 at 11:10 AM. She stated she visited Resident #2 frequently and knew the sutures were not removed until the resident returned to the neurologist on 2/18/15. The family member stated the resident had complained to multiple staff about the sutures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 6 itching and pulling, but no one had taken them out. On 3/19/15 at 11:36 PM, the treatment nurse was interviewed. The Treatment Nurse stated Resident #2 had a surgical incision on the back of his neck. She stated the area was clean,dry and well approximated. The Treatment nurse stated Resident #2's sutures were not removed at the facility because there was not a physician's order to remove the sutures. The Treatment Nurse stated all admission orders were transcribed from the hospital discharge summary. She added one nurse would transcribe the orders and then a second nurse would review for accuracy and sign as reviewed and accurate. The Treatment Nurse stated non-pressure ulcer wound care sheets were typically kept on surgical wounds that included weekly documentation of the site. The Treatment Nurse acknowledged she had not completed weekly wound care sheets for Resident #2 since the area was essentially healed. The Treatment Nurse reviewed the discharge summary for Resident #2 and acknowledged an order to remove his sutures in the facility on 1/19/15 had been present on his admission to the facility. The nurse added she had been unaware of the order and therefore, she had not removed the sutures. She had heard from someone, Resident #2's sutures had not been removed until the resident returned to the neurologist on 2/18/15. An interview was held with the Administrator on 3/19/15 at 1:20 PM. He stated he had spoken to previous Interim Administrator who stated she had written a grievance and done an investigation on why physician's orders to remove the sutures for Resident #2 had not been followed. The	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 7	F 309		

Administrator stated he had reviewed the grievance log and had not found a concern written and could find no written documentation of an investigation.

A telephone interview was held with Nurse #5 on 3/19/15 at 1:36 PM. Nurse #5 had signed as completing the Admission Assessment for Resident #2. She stated admission orders were transcribed from the hospital discharge summary. The facility process included one nurse transcribed the orders and a second nurse checked for accuracy and signed the orders were accurate. Nurse #5 stated if a resident had a wound, surgical or otherwise, during the assessment the areas were marked on the body figure included on the assessment form with wound location and type identified. The nurse added description of the wound would be included in the nurse's notes. The nurse stated she remembered Resident #2, but did not remember specifically if she had completed his admission assessment. She added if she had signed the admission assessment form, the she was sure she had completed the admission assessment. Nurse #5 stated she remembered Resident #2 wore a neck brace which she had removed during the assessment to reveal a straight surgical wound on his neck with stitches. The nurse described the wound as clean and dry. The nurse stated she remembered two admissions on the day Resident #2 had been admitted. Nurse #5 stated she had completed the orders for one admission and Nurse #4 had helped her by transcribing the orders for Resident #2's admission. She stated she did not remember completing a second check for Resident #2's admission orders. Nurse #5 stated she first became aware of the need for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 8	F 309		

sutures to be removed when a family member of Resident #2 asked when the sutures would be removed. The nurse stated she reviewed the TAR and reported to the family member the sutures would be removed on 1/19/15. The nurse added the next she knew of the sutures was after the resident returned from his follow up neurology appointment in February. At that time, she found out the sutures had been removed at the neurologist's office. Nurse #5 stated she tried to find the treatment record for January so she could review it, but was unable to locate the TAR for Resident #2. Nurse #5 stated there had been no in-services or education related to the missed treatment order for Resident #2.

Family member #2 was interviewed via telephone on 3/19/15 at 1:50 PM. Family member #2 stated she had accompanied Resident #2 when he went for his February neurology appointment. The family member added the sutures were still in place when they arrived for the appointment. She added she observed the skin around the sutures was raised up and almost covered the sutures. On the resident's pillow, she had observed spots of blood.

At 1:54 PM on 3/19/15, Resident #2 was interviewed by telephone. He stated he had no trouble with the facility except for the fact they had not removed the sutures. Resident #2 stated he had complained to a nurse about the sutures itching, the nurse would look at the sutures, but had not offered to remove the sutures. Resident #2 added the sutures were finally removed when he went for his follow up neurology appointment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 9	F 309		

2. Resident #5 was admitted on 3/3/15 with diagnoses of cellulitis, sepsis and an abscess on the left lower extremity times 2.
Review of a hospital discharge summary, dated 3/3/15, indicated Resident #5 had 2 abscesses on his left lower leg that had required drainage. The wounds had been left open.
Review of the facility's 3/3/15 admission orders for Resident #5 indicated the resident's left lower leg incisions should be cleansed with normal saline, packed with normal saline wet to dry dressing, covered with gauze and wrapped with kerlix and an ace wrap twice daily.
The March 2015 Treatment Administration Record (TAR) was reviewed and orders for the twice daily dressing changes to the left lower extremity were found. The designated times for dressing changes were 7:00 AM to 7:00 PM shift and 7:00 PM to 7:00 AM shift. There was no documentation the dressing changes had been completed more than once daily. No initials were seen for the 7:00 PM to 7:00 AM dressing change.
On 3/10/15, the facility had completed a Brief Interview for Mental Status that identified Resident # 5 as cognitively intact.
Resident #5's care plan, dated 3/16/15 identified actual skin impairment due to a surgical incision on his left lower extremity. Approaches to aid in healing and prevention of complications included weekly observations and documentation on a non-pressure related skin impairment form and wound care as ordered.
An interview was held with Resident #5 on 3/18/15 at 4:37 PM. A bandage was observed on the resident's lower left leg. Resident #5 stated the bandage was changed once a day at about 6:00 PM.
Nurse #1 was interviewed on 3/19/15 at 10:42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 309	Continued From page 10 AM. The nurse described Resident #5 as alert and oriented. The nurse stated facility admission orders were transcribed from the discharge summary from the hospital and then verified with the facility physician. The transcription process included a second nurse checking the orders for accuracy and signing the Medication Administration Record as reviewed and accurate. The Treatment Nurse was interviewed on 3/19/15 at 3:30 PM. The nurse stated the resident's dressings were done daily. On review of the Treatment Administration Record, the nurse acknowledged entries for twice daily dressing changes. She stated she doubted the resident's treatment was done twice daily adding when she was not in the building, or if she was passing medications, the hall nurses were expected to complete treatments. The Treatment nurse stated Resident #5 was alert, oriented and reliable. An observation was made of the resident's surgical wound with the Treatment Nurse on 3/19/15 at 3:50 PM. A medial wound on the left lower leg appeared to be approximately 6 inches long by 1/2 to 1 inch wide. On the lateral aspect of the left lower leg, the resident had a surgical wound approximately 3-4 inches long by 1/2 inch wide. Both wounds were free of drainage or odor. The wound bed was pink.	F 309		