STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345343			B. WING		C	C 1/07/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	INTER HEALTH AND REI	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 309 SS=D	483.25 PROVIDE CA HIGHEST WELL BEI		F 3	09		1/22/16
	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 record review, resident and staff interviews, and observations, the facility failed to ensure there was a clear order for oxygen and it was being administered as ordered by the physician for 3 of 3 residents reviewed for well-being Resident #31, Resident #6, Resident #248). Findings included: 1) Resident #31 was admitted to the facility on 10/14/14. Diagnoses included: Hypertension, Renal Failure, Diabetes Mellitus, Hyperlipidemia, Atrial Fibrillation, Polyneuropathy, and Chronic Kidney Disease. A review of the most recent Minimum Data Set (MDS) dated 10/29/15, indicated the resident is alert and oriented, and had a Brief Interview for Mental Status (BIMS) of 15. She required extensive to one person physical assistance with Activities of Daily Living (ADLs) and bed mobility, and required extensive to two person physical assistance with transfers. Oxygen use was not indicated on her MDS dated 10/29/15. The current care plan indicated the resident was on oxygen therapy.					
				Resident #6 #31's physici oxygen were reviewed and needed on 1/7/16 by the A Director of Nursing to valid of oxygen liter flow the res receive. Residents 36 and physically assessed by nu managers to check the res saturation levels and ensu were receiving oxygen at a flow ordered. Resident #2 hospitalized during time of Resident was readmitted of orders for oxygen were re of admission. An audit of resident physic began on 1/7/16 and com to identify all residents util residents identified with oo were checked to ensure th receiving the accurate liter as ordered by the physicia	d clarified as Assistant date the amount sident was to I #31 were urse unit sident's oxygen ure the residents the correct liter 48 was f survey. on 1/9/16 and viewed on day cian orders pleted on 1/8/16 izing oxygen. All kygen orders ney were r flow of oxygen	

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.

C 01/07/2016
(X5) COMPLETIC DATE
I

If continuation sheet Page 2 of 9

		ID HUMAN SERVICES					FORM): 01/28/2016 MAPPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /		CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345343	B. WING				C 01/07/2016	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
				17	700 WAYNE MEMORIAL DRIVE			
BRIAN CE	INTER HEALTH AND REP	HABILITATION/GOLDSBORO			OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD B		(X5) COMPLETION DATE
F 309	therapy. She was also therapy. At 4:00 PM on 1/6/16 Resident #6, along wi that her oxygen conce per minute (L/min). Ni know the resident's of was not the unit mana Resident #6's orders O2 ordered at 4L/min On 1/7/16 at 10:55 AI up in her wheelchair v running at 1.5L/min. F supposed to be at 4L/ orders were verified at 4L/min via nasal can At 10:58 AM on 1/7/10 Resident #6's chart th 4L/min via NC. At 11:00 AM on 1/7/10 # 6's room and verifie was set at 1.5 L/min at the chart again and cl order she read was fo On 1/7/16, at 11:03 A expectation was that supposed to be the pe tubing, changing tubin she expected all shifts and check the concer O 1/7/16 at 12:35 PM expectation was for th correct the oxygen do	received oxygen (O2) o care planned for O2 during an observation of ith Nurse #1, it was noted entrator was set at 1.5 liters urse #1 stated she did not rder for oxygen because she ager for the 200 hall station. were reviewed and showed via nasal cannula (NC). M, Resident #6 was sitting with oxygen concentrator Resident #6 stated she was /min, not 1.5. Physician again and current order read nula continuous oxygen. 6, Nurse #2 verified in he order for oxygen was 6 Nurse #2 visited Resident ed the oxygen concentrator and stated she would check larify the order because the or 4 L/min. M, the DON stated her the 11-7 shift nurse was erson checking the oxygen ng, water bottles, etc., but is to verify the oxygen rate ntrator settings. J, Resident #6's oxygen back to 4 L/min via NC.	F	309		,		

Facility ID: 922984

If continuation sheet Page 3 of 9

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM): 01/28/2016 APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED			
	345343		B. WING		_	01/) 07/2016
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BRIAN CE	ENTER HEALTH AND REP	HABILITATION/GOLDSBORO		700 WAYNE MEMORIAL I GOLDSBORO, NC 2753			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	11/18/2015 status pos respiratory distress. H included CHF, acute in hypercapnia (A condit carbon dioxide (CO 2 fibrillation, and asthm MDS information, last that Resident #248 w independent or only m ADLs. A review of Resident if physician orders for of sats) to be monitored day and to keep the m were greater than 929 12/11/15 and a revisio order did not indicate the resident was supp On 1/6/16 at 4:55 PM who worked with Res did not go by any orded documented on the re- in her assessment. SI concentrator when re- and it was set at 3L/m On 1/7/16 at 10:00 AI was not sure what Re- for O2 was and was m an order or any docum O2 she was supposed basis in the chart or th record. She reported concentrator had bee she checked it at the	a admitted to the facility on at hospitalization for acute ler diagnosis history respiratory failure with tion of abnormally elevated) levels in the blood.) atrial a. dated 12/16/15, indicated as cognitively intact and equired supervision with #248's chart showed xygen saturation rate (O2 every four hours during the esident off of O2 if O2 sats % with a start date of on date of 12/23/15. The the rate or amount of O2 bosed to be administered. , the occupational therapist ident #248 reported that she er in chart when she esident's respiratory status he had just looked at O2 sident was being evaluated hin. M, Nurse #3 reported she esident #248's regular order not sure why there was not mentation of the amount of d to receive on a regular he electronic medical	F 309				

If continuation sheet Page 4 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/28/201 DRM APPROVE NO. 0938-039	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345343			B. WING			C 01/07/2016		
NAME OF PROVIDER OR SUPPLIER			•	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
		HABILITATION/GOLDSBORO		1700	0 WAYNE MEMORIAL DRIVE			
BRIAN CL		HABILITATION/GOLDSBORG		GO	LDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 309	an order on Resident of O2 she should hav regular basis and wen nursing staff would hav oxygen the resident s continuously. The DC expect that all resider order specifying the r to be administered. Based on record revie interviews, and obser ensure there was a cl was being administer physician for 3 of 3 re well-being Resident # #248). Findings included: 1) Resident #31 was 10/14/14. Diagnoses Renal Failure, Diabet Atrial Fibrillation, Poly Kidney Disease. A review of the most (MDS) dated 10/29/19 alert and oriented, an Mental Status (BIMS) extensive to one pers Activities of Daily Livi and required extensiv assistance with transf indicated on her MDS The current care plan on oxygen therapy. A record review indica dated 11/29/15 read, During an observation	ted they were unable to find #248's chart for the amount re been receiving on a re unable to indicate how ave known how much should have received DN stated that she would nts on O2 would have an ate and frequency of oxygen ew, resident and staff vations, the facility failed to lear order for oxygen and it red as ordered by the esidents reviewed for 431, Resident #6, Resident admitted to the facility on a included: Hypertension, res Mellitus, Hyperlipidemia, yneuropathy, and Chronic recent Minimum Data Set 5, indicated the resident is id had a Brief Interview for o of 15. She required son physical assistance with ng (ADLs) and bed mobility, ye to two person physical fers. Oxygen use was not	F	309				

Facility ID: 922984

If continuation sheet Page 5 of 9

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 01/2 FORM APPR OMB NO. 0938	ROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	345343	B. WING		C 01/07/201	6
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
BRIAN CENTER HEALTH AND RE			1700 WAYNE MEMORIAL DRIVE		
BRAN CENTER REALMAND RE	HABILITATION/GOLDSBORG		GOLDSBORO, NC 27534		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL	(5) LETION NTE
An interview with resident supposed to receive An interview with nur 1/6/16 at 2:50 pm, sh oxygen order was for oxygen per minute wi An observation on 1/ with nurse #1 presen oxygen concentrator Liters per minute and concentrator to 2 Lite An interview with nur 1/6/16 at 3:50 pm. St the resident's oxyger every morning and th resident's should also oxygen concentrator there was no record this information, she check". She indicate continuous oxygen b verified the physiciar An interview was cor Nursing on 1/6/16 at expectation was for e resident's oxygen co 2. Resident # 6 was August 2014 and wa a diagnosis history th hypertension, chronid disease (COPD), cor and hyperlipidemia. The most recent Min 10/30/15, indicated th cognitively intact and	via nasal cannula (NC). ident #31 on 1/6/16 at 2:30 She indicated that she was 2 L/min, not 3 L/min. se #1 was conducted on he indicated the resident's 2 Liters of continuous a nasal cannula. 6/16 at 3:00 pm was made t. Nurse #1 verified the for resident #31 was set at 3 a djusted the oxygen ers per minute. se #1 was conducted on he indicated she checked n concentrators on her unit he nurses assigned to the o check the resident's delivery level. She indicated of documentation to reflect stated, "I just know who to do the resident received ecause "she likes it on", but n order was for "as needed ". hducted with the Director of 4:22 pm. She indicated her each nurse to monitor the ncentrator settings. admitted to the facility in s readmitted on 9/18/14 with hat included essential c obstructive pulmonary ngestive heart failure (CHF),	F 3(09		

Facility ID: 922984

If continuation sheet Page 6 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345343	B. WING _			C 01/07/2016		
NAME OF P			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
			1	700 WAYNE MEMORIAL DRIVE				
BRIAN CE	INTER HEALTH AND REI	HABILITATION/GOLDSBORO		G	GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Continued From page therapy.		F	309				
	Resident #6, along wi that her oxygen conce per minute (L/min). N know the resident's o was not the unit mana Resident #6's orders O2 ordered at 4L/min On 1/7/16 at 10:55 AI up in her wheelchair y running at 1.5L/min. F supposed to be at 4L orders were verified a 4L/min via nasal can At 10:58 AM on 1/7/1 Resident #6's chart th 4L/min via NC. At 11:00 AM on 1/7/10 # 6's room and verifie was set at 1.5 L/min a the chart again and cl order she read was fo On 1/7/16, at 11:03 A expectation was that supposed to be the p- tubing, changing tubin she expected all shifts and check the concer O 1/7/16 at 12:35 PM expectation was for th correct the oxygen do resident was receiving oxygen. 3. Resident #248 was	M, the DON stated her the 11-7 shift nurse was erson checking the oxygen ng, water bottles, etc., but s to verify the oxygen rate ntrator settings. , Resident #6's oxygen back to 4 L/min via NC.						

If continuation sheet Page 7 of 9

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY IPLETED
			AL DOLLDING			С
		345343	B. WING		0	1/07/2016
NAME OF PR	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO				1700 WAYNE MEMORIAL DRIVE		
BRIAN CENTER REALTH AND REHABILITATION/GOLDSBORD			GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Continued From page	e 7	F 309	9		
	respiratory distress.					
		respiratory failure with				
	hypercapnia (A condi	ition of abnormally elevated				
		2) levels in the blood.) atrial				
	fibrillation, and asthm					
		t dated 12/16/15, indicated /as cognitively intact and				
		required supervision with				
	ADLs.					
	-	#248's chart showed				
	physician orders for o	oxygen saturation rate (O2				
	-	l every four hours during the				
		resident off of O2 if O2 sats				
		% with a start date of on date of 12/23/15. The				
		the rate or amount of O2				
		posed to be administered.				
		1, the occupational therapist				
		sident #248 reported that she				
	did not go by any ord					
		esident's respiratory status				
		the had just looked at O2 sident was being evaluated				
	and it was set at 3L/n	-				
		M, Nurse #3 reported she				
		esident #248's regular order				
		not sure why there was not				
	-	mentation of the amount of to receive on a regular				
		the electronic medical				
	record. She reported					
		en set at 3L/min whenever				
	she checked it at the	beginning of her shifts.				
	On 1/7/16 at 1:20 PM	1, the DON and Corporate				
		ited they were unable to find				
		t #248's chart for the amount				

If continuation sheet Page 8 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345343 B. WING 01/07/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/07/2016 BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/28/2016 M APPROVED D. 0938-0391
Image: Name of PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO STREET ADDRESS, CITY, STATE, ZIP CODE (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) COMPLETIC DATE F 309 Continued From page 8 of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen F 309				, ,			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO 1700 WAYNE MEMORIAL DRIVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH OCRRECTIVE ACTION SHOULD BE COMPLETIC F 309 Continued From page 8 F 309 F 309 F 309 F 309 Continued From page 8 F 309 F 309 of O2 she should have been receiving on a F 309 F 309 regular basis and were unable to indicate how nursing staff would have known how much F 309 oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen ID ID			345343	B. WING				
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO 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) COMPLETIC DATE F 309 Continued From page 8 of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen F 309	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
(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) COMPLETIC DATE F 309 Continued From page 8 of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen F 309	BRIAN CE	ENTER HEALTH AND REI	HABILITATION/GOLDSBORO					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC DATE F 309 Continued From page 8 of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen F 309					G			
of O2 she should have been receiving on a regular basis and were unable to indicate how nursing staff would have known how much oxygen the resident should have received continuously. The DON stated that she would expect that all residents on O2 would have an order specifying the rate and frequency of oxygen	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 309	of O2 she should hav regular basis and wer nursing staff would ha oxygen the resident s continuously. The DC expect that all resider order specifying the ra	e been receiving on a re unable to indicate how ave known how much should have received N stated that she would nts on O2 would have an	F	309	DEFICIENCY)		

Facility ID: 922984

If continuation sheet Page 9 of 9