STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345323	A. BUILDING: _____ B. WING _____	2/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHABILITATIO	**647 S RAILROAD STREET BOX 966 WALLACE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to document dressing changes for 1 of 3 sampled residents reviewed for accuracy of clinical records (Resident #2).
The findings included:

Review of medical records revealed Resident #2 had been discharged with return anticipated to the local hospital on 1/7/15 and readmitted to the facility on 1/25/16 with discharge diagnoses of stroke, peripheral vascular disease and decubitus ulcers.

The resident was discharged back out to an acute setting on 2/4/16 and has not returned.

The most recent quarterly Minimum Data Set (MDS) dated 12/26/16 documented the resident had 2 venous/arterial ulcers.

The most recent Minimum Data Set (MDS) dated 1/7/16 documented Resident #2 had good short term memory with moderately impaired cognitive skills for daily decision making. The resident was listed as having no delirium, psychosis, behaviors or rejection of care and needed total to extensive assistance of staff for all activities of daily living (ADL). The MDS documented the resident had a urinary catheter, was always incontinent of his bowels, was at risk for pressure ulcers and had 2 unstageable pressure ulcers with eschar and two unstageable suspected deep tissue injuries with the largest ulcer measuring 11 cm length by 3.0 cm width by 0.2 cm depth. The status of venous/arterial ulcers was not part of the questions asked in the discharge assessment.

Review of the medical records revealed the Treatment Nurse (TN) documented all pressure and non-pressure ulcers on her weekly log on 1/25/16. The Resident was documented to have 9 non-pressure venous ulcer wounds (right heel, right great toe, left 3rd toe, left lateral outer leg, left outer ankle, left lateral outer foot, right inner lateral foot, right great toe and right outer foot) and one pressure ulcer wound to the sacrum.

Review of medical records revealed that on 1/25/16 the admission orders were verified and signed off on 1/26/16 by the Physician to apply Silvadene 1% cream topically to wounds daily.

The above isolated deficiencies pose no actual harm to the residents

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F 514	Continued From Page 1

The January 2016 Medication Administration Record (MAR) on 1/25/16 listed Silvadene 1% cream apply topically to wounds daily. The MAR was updated (no date) to say Silvadene 1% cream apply topically to wounds daily on sacrum and bilateral heals.

Upon review of the medical records, it was revealed that there was no documentation of any treatment being given to the venous ulcer or pressure ulcers wounds from 1/28/15 through 1/30/15 in the medication administration record (MAR), treatment log or nurses notes. Documentation was found of daily wound treatment being done on 1/31/16 until discharged back out to the hospital.

In an interview with the TN on 2/11/16 at 11:00 AM it was revealed that when a resident was admitted/readmitted to the facility, a skin check was done and if there were any skin issues at that time or new or worsening skin issues later the facility would start treatment using the facility standing orders and would always notify the family and physician. The nurse stated Resident #2 had multiple skin issues noted on readmission to the facility on 1/25/16 that had been measured, treated, and documented. The nurse stated she had not worked as the treatment nurse on 1/28/16 through 1/30/16 and the Resident ' s hall nurse would be responsible for giving any treatment on those days. The TN stated the 11-7 shift nurses would not do the daily wound dressings but might do prn dressing changes if needed. She further stated that she could not find any documentation of the sacral pressure ulcer treatment being done on 1/28/16 through 1/30/16 in her treatment log, the MAR, in the nurse ' s notes or anywhere in the chart.

Nurse #1, who took care of Resident #2 on 1/28/16 (3-11 shift), stated in an interview 2/11/16 at 3:25 PM she had not done any wound treatments on the Resident 1/28/16 (3-11 shift).

Nurse #2, who took care of the Resident #2 on 1/29/16 (7-3 shift), stated in an interview on 2/ 11/16 at 5:25 PM that she had not changed any of Resident #2 ' s wound dressings on that day because the Resident had been in out of the facility for dialysis.

Nurse #3, who took care of the Resident #2 on 1/29/16 (3-11 shift) stated in an interview on 2/11/16 at 3:21 PM that she was sure she had done the dressing but had failed to document that she had. The nurse stated she should initial/sign her name when she does any treatment.

Nurse #4, who took care of the Resident #2 on 1/30/16 (7-3 shift) stated in an interview on 2/ 11/16 at 4:25 PM that the treatment nurse was not there on that day and is usually " a stickler " about making sure treatments are done and she got so busy taking care of the residents that she forgot to sign out that the treatment was done. She further stated that she knows she should sign out that treatment is done.

Nurse #5, who took care of Resident #2 on 1/28/16 (7-3 shift) and 1/30/16 (3- 11 shift), stated in an interview on 2/11/16 at 2:37 PM that stated she could recall that on 1/30/16 the family of the resident was at the facility and voiced frustration at the condition or Resident #2 wounds. Nurse #5 stated she had looked at the wounds and had reiterated to the family member that the dressings needed to be done daily and had made sure the Resident ' s dressings were taken care of and his needs met on that day. Nurse #1 further stated she should have documented that she did the treatment and failed to do so.

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F 514	Continued From Page 2 The Director of Nursing stated in an interview on 2/11/16 at 2:21 PM she expects her staff to always initial/sign when treatment was done and the staff should have done so. The Administrator stated in an interview on 2/11/16 at 2:25 PM her expectations are that the nurses would follow the physician orders and document when care was done.