STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide and maintain a safe and comfortable interior on two of five resident halls (Halls 500 and 600). The findings included: 1. On 10/17/16 at 9:17 a.m. an inspection of Room 610 revealed a leaking faucet after the water was turned off. There was a non-functioning bathroom switch for the light above the sink. 2. On 10/17/16 at 9:24 a.m. an inspection of Room 613 revealed ripples in the painted surface of the wall above the heating and air conditioning unit. Drywall was exposed. 3. On 10/17/16 at 9:35 a.m. an inspection of Room 617 revealed multiple areas of exposed drywall and marring on all walls of the bathroom. On 10/17/16 at 12:22 p.m. an inspection of Room 608 revealed a loose non-working handle on one drawer of the bedside table. The screw for the right side of the handle was missing causing it to hang down. 4. On 10/20/16 at 11:40 a.m. an inspection of Room 607 revealed a hole in the wall approximately 1 x 1 inch above the heating and air conditioning unit. On 10/20/16 at 11:45 a.m. an inspection of Room 503 revealed one bracket of the toilet paper holder in the bathroom was missing, leaving the fixture unable to hold toilet	F 253	F253 HOUSEKEEPING & MAINTENANCE SERVICES: 11/17/16 Corrective Action: All areas identified in the citation for 500 and 600 Halls have been addressed immediately after the survey. We completed a thorough review of both Halls, including bathrooms, patient rooms, Hallways and Call light systems. Leaking Faucets were repaired, Light switch in all bathrooms not working were repaired, most were the lights were burnt out, Holes in the walls were filled, sanded and will be painted, Bathroom Toilets were repaired as needed, Toilet Paper holders were either secured to the walls or replaced as needed, Bedside cabinets and handles repaired or replaced as needed on both Units. Identification other areas: For Repairs needed at all 3 Nurses Stations which includes 100, 200, 300, 400, 500, & 600 Halls, there is a Notebook placed at each Nurses Station designated for the staff to write in the notebook items they feel need to be repaired. A member of the Maintenance Department will review the notebooks	11/14/16

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

Electronically Signed | 11/15/2016

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F 253	Continued From page 1 paper. 5. On 10/20/16 at 11:50 a.m. an inspection of Room 507 revealed no toilet paper holder was present in the bathroom. There were two small holes in the wall on either side where the brackets had been in place. The lower hole on the left side contained a loose screw which could be pulled out of the wall. During an interview with the Maintenance Director on 10/20/16 at 12:35 p.m., he described the process for identifying items needing repair. Staff members were instructed to record areas of concern in notebooks designated for that purpose at three nurses ' station throughout the building. A member of the maintenance team reviews the notebooks daily and prioritizes the work. A walk-through inspection of the areas of concern was conducted with the Maintenance Director on 10/20/16 at 1:08 p.m. He indicated that some of the issues presented during the walk-through tour should have been identified during the Maintenance Department ' s monthly room inspections. In an interview with the Administrator on 10/20/16 at 4:53 p.m., she shared her expectation that when items were in disrepair they " needed to be fixed in a timely manner. "	F 253	daily and prioritize the work to be completed as soon as possible. All Staff will be educated as to the Notebooks and how they are to be used. Systemic Changes: Weekly the maintenance Director will make his rounds throughout the entire building and use the Notebooks from each nurse□s station to be assured the items needing repair have been completed. Also, we have a program called: TELS, it is an innovative, web-based building management system that helps outline maintenance of equipment, monitors if items were completed and helps too with Life Safety. This system will be followed as recommended. This will be reviewed by the Administrator monthly. Monitoring: The corrective action noted above will be reported monthly to the QAPI Committee for the next 4 months to assure maintaining the corrective action. This Plan of Correction is the facilities allegation of compliance.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		11/14/16

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F 281	Continued From page 2 by: Based on record reviews and staff interviews the facility failed to implement orders that were written by the physician on 2 of 2 residents (Resident #13 and Resident #151) reviewed for unnecessary medications. Findings included: 1. Resident #13 was admitted on 8/11/16. Diagnoses in part included depression, anxiety, and dementia. A review of the MDS quarterly assessment dated 8/25/16 revealed the resident was cognitively impaired. The resident was noted to be receiving the antidepressant and antianxiety medications. A review of the care plans initiated on 8/11/16 and updated on 8/23/16 revealed a plan of care for psychoactive medications and for depression and anxiety. The interventions included to monitor for behaviors, report any signs or symptoms of adverse reactions to the medications and consult mental health as needed. A review of the physician orders revealed the resident was prescribed Paroxetine (a medication for depression) 10 milligrams daily. A review of the October electronic Medication Administration Record (eMAR) on 10/19/16 revealed the resident was given the antidepressant medication 10 milligrams daily as ordered. An interview with Nurse #1 on 10/19/16 at 10:12 am revealed the resident would yell out at times on the day shift. Nurse #1 reported she slept in frequent naps and had a fair to good appetite. An interview with NA #1 on 10/19/16 at 10:20 am revealed the resident was usually pleasant but would have periods of yelling out. A review of a recommendation by the Mental	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS. Corrective Action: The medical director was notified of the deficient practices related resident #13 and resident #151. Medication error reports were completed and c clarification orders were written, transcribed and initiated. Residents # 13 and # 151 are currently receiving medications per order/recommendations. Identification of others: All facility residents have to potential to be affected by this deficient practice. An audit was completed of orders/ Recommendations written in the last 30 days to ensure compliance and appropriate transcription. Systemic Changes: An Adhoc meeting was held with Medical Director and Nurse Practitioners with the Nursing Leadership Team with emphasis on clarification for the process of writing, transcribing, and the implementation of physician orders was completed. Date of completion 10-20-2016. Facility nursing staffs were provided re-education on the obtaining, transcribing and timely initiation of physician orders. This was completed by the DNS on 11-14-2016. Newly hired licensed personnel will be provided education related to the facility policy and procedure on transcription and timely initiation of MD orders. This will be completed by the staff development coordinator. The facility medical director was made aware of noted errors and medication error reports were completed	

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F 281	Continued From page 3 Health Nurse Practitioner (MHNP) consult dated 10/12/16 revealed the resident had a history of dementia, severe in nature, and would yell out per staff. Record review revealed an order was written by the MHNP on 10/12/16 to taper and discontinue the Paroxetine and start Zoloft (a medication to treat anxiety and depression). The order was to discontinue the Paroxetine 10 milligrams to 5 milligrams for one week and start Zoloft 25 milligrams daily for 2 weeks and then adjust the dose to 50 milligrams daily. An interview with the ADON at 1:35 pm on 10/19/16 revealed the process for writing orders. Once a physician had seen a resident, they would write a note. If there were any orders it was written on a physician order sheet and placed in the doctor's order book and signed. The doctor ' s order book contained tabs which were numbered for the days in the month. The orders were placed under the day of the month the order was written. The order was then put into the computer system by the nurse at the end of each shift. The ADON took the orders out of the book every morning and brought them to the morning meeting to review. The ADON would then place the order in another book called the master book and verify that the order was put into the computer system by signing her name in red ink. The orders were then placed in a stack for the physicians to sign. Once they were signed, the order was then filed in the resident ' s chart. The ADON reported the orders (for the Paroxetine and Zoloft) were not signed by the MHNP so the nurse did not put the orders in the computer system. The ADON confirmed the orders were not implemented and stated it was the nurse ' s responsibility to make sure the order was not missed.	F 281	and clarification of the orders were obtained and initiated. Completed 11-14-2016 Monitoring: The DON or designee will randomly audit orders written within a 7 day period for three months to assure compliance with the transcription and initiation of physician orders. An audit tool was created to reflect these findings. Start date 11-14-2016. All data collected will be submitted to the monthly QAPI Committee for review and recommendations x 3 months. This Plan of Correction is the facilities allegation of compliance.	

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F 281	Continued From page 4	F 281		

An interview with the MHNP via phone on 10/20/16 at 1:30 pm revealed that she wrote the order on 10/12/16. The process was to put the order on a physician order sheet and sign or initial the order. On 10/19/16 she recalled the ADON had asked her to initial the order written on 10/12/16. The MHNP reported she knew the orders she wrote were implemented when she would go through her orders and sign a hard copy. She reported she had a stack of them to go through and sign. The MHNP stated that she did not reconcile orders.

2. Resident #151 was admitted on 8/30/16. Diagnoses included dementia with behaviors, anxiety, and depression.

A review of the care plans revealed an updated plan of care dated 9/7/16 for psychoactive medications. The interventions included to monitor for behaviors, report any signs or symptoms of adverse reactions to medications and consult mental health as needed.

The Minimum Data Set (MDS) quarterly assessment dated 9/12/16 revealed the resident was cognitively impaired. Resident #151 had received antipsychotic, antianxiety, and anti-depressant medications.

A review of Resident #151 ' s medication orders revealed the resident was on
Zyprexa (a medication to treat dementia with behaviors), 5 milligrams once daily at night, and Aripiprazole (a medication for dementia with behaviors) 2 milligrams once daily at night. Alprazolam (a medication for anxiety) 0.25 milligrams one tablet every 4 hours as needed, and Sertraline (a medication for depression) 50 milligrams daily.

A record review revealed a routine visit by the General Nurse Practioner (GNP) was done on

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F 281	Continued From page 5	F 281		

10/5/16. The GNP stated in this assessment that a mental health consult had been ordered.
An interview with Nurse #3 on 10/19/16 at 11:00 am revealed at times the resident would yell out. Nurse # 3 stated that the resident would not say anything, she would just yell. Nurse #3 reported the responsible party (RP) requested the resident get an antianxiety medication in the morning to help with yelling out.
A review of the October eMAR revealed the medication Alprazolam (antianxiety) was given 12 times during the month of October. Nurse #3 reported the resident slept better in the morning but was usually up at night. Nurse #3 reported the anti-anxiety was given during the night but was only partially effective.
An interview with the Assistant Director of Nursing (ADON) on 10/19/16 at 10:40 am reported Resident #151 had no behaviors all day, but she would yell out at night and needed to be redirected.
An interview with the Medical Assistant (Med Aid #1) on 10/19/16 at 10:45 am revealed the resident cried out at times during the day but mostly at night.
A review of the physician orders written on 10/5/16 through 10/18/16 revealed there was no order written for this consult.
An interview with the ADON on 10/19/16 at 11:15 am revealed that she would check with the GNP to confirm if she still wanted a mental health consult for Resident #151. The ADON reported the GNP confirmed she wanted the order carried out. The ADON reported the Mental Health Nurse Practioner (MHNP) assessed the resident and wrote the order on 10/19/16. The ADON explained the GNP forgot to write the order for the consult.
An interview with the GNP on 10/20/16 at 1:30

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F 281	Continued From page 6 pm revealed that she wrote the order on her assessment sheet, but the order never made it to the physician's order sheet in the physician ' s order book. The GNP further added that the process for ensuring orders were transcribed was that after her and her assistant visit each resident, the GNP verbally completed the assessment and any orders to the assistant while she typed it into the computer system. Once they are finished, they reviewed the orders and wrote the orders in the physician ' s order book. The GNP reported she overlooked it and did not write the order for the consult on 10/5/16. An interview with the Administrator on 10/20/16 at 5:00 pm revealed her expectation of the nursing staff was to make sure any physician orders that were written were implemented. Her expectation of the NP ' s was to ensure any orders they wrote were implemented.	F 281		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain a functional resident call system for 8 of 16 residents observed on the 600 hall. The findings included: 1. On 10/17/16 at 8:32 a.m. an inspection of Room 612 revealed that the room and bathroom call bells did not light above the door outside the	F 463	T463 RESIDENT CALL SYSTEM, ROOMS/TOILET/BATHS: Corrective Action: All of the Rooms & Bathrooms on 500 and 600 Halls were reviewed for the lights above patients doors and/or the bathroom call bell not lighting up when the call bell	11/14/16

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F 463	Continued From page 7 residents ' room when activated. The call bell in the bathroom did not signal an alarm at the nurses ' station. 2. On 10/17/16 at 9:24 a.m. an inspection of Room 613 revealed that the room and bathroom call bells did not light above the door outside the residents ' room when activated. 3. On 10/18/16 at 11:35 a.m. an inspection of Room 615 revealed the room and bathroom call bells did not light above the door outside the residents ' room when activated. 4. On 10/18/16 at 11:41 a.m. an inspection of Room 620 revealed the room and bathroom call bells did not light above the door outside the residents ' room when activated. During an interview with the Maintenance Director on 10/20/16 at 12:35 p.m., he described the process for identifying items needing repair. Staff members were instructed to record areas of concern in notebooks designated for that purpose at three nurses ' station throughout the building. A member of the maintenance team reviewed the notebooks daily and prioritized the work. A walk-through inspection of the areas of concern was conducted with the Maintenance Director on 10/20/16 at 1:08 p.m. He acknowledged that some of the issues presented during the walk-through tour should have been identified during the Maintenance Department ' s monthly room inspections. He acknowledged that both components of the resident call system (light and sound) were designed to work together. In an interview with the Administrator on 10/20/16 at 4:53 p.m., she shared her expectation that when items were in disrepair they " needed to be fixed in a timely manner. "	F 463	was activated. All of the lights bulbs above the doors have been replaced with new bulb that works. Also at the nurses station on the main unit: we called in the company who installed the system and the only thing wrong at that main unit was all the lighting system inside the unit needed to be replaced. This was done and now all of the main system is working and all lighting above patient room activate when pulled along with the bathroom call bell are working properly. Identification of Other Areas: For Repairs needed at all 3 Nurses Stations: which includes 100, 200, 300, 400, 500, & 600 Halls, maintenance will check each hall to be sure that all call bells are working properly and all maintenance issues will be repaired along with placing a Notebook at each Nurses Station designated for the staff to write in the notebook items they feel need to be repaired. A member of the Maintenance Department will review the notebooks daily and prioritize the work to be completed as soon as possible. All Staff will be educated as to the Notebooks and how they are to be used. Systemic Changes: Weekly the maintenance Director will make his rounds throughout the entire building and use the Notebooks from each nurse s station to be assured the items needing repair have been completed. Also, we have a program called: TELS, it is an innovative, web-based building	

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F 463	Continued From page 8	F 463	management system that helps outline maintenance of equipment, monitors if items were completed and helps too with Life Safety. This system will be followed as recommended. Monitoring: The corrective action noted above will be reported monthly to the QAPI Committee for the next 4 month to assure maintaining the corrective action. This Plan of Correction is the facilities allegation of compliance	