PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345332	B. WING		06/15/2017
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895	1 33/10/2017
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 000	INITIAL COMMENTS		F 0	00	
	allegation investigation VIO111. Intakes NC0 NC00125265	e cited from the complaint on of 6/15/2017. Event ID # 0128476, NC00125382,			
F 157 SS=D	(INJURY/DECLINE/R	ROOM, ETC)	F 1:	57	7/13/17
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident			
		ving the resident which as the potential for requiring n;			
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or			
	a need to discontinue	erse consequences, or to			
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).				
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the			
ADODATODY	DIDECTOR'S OR DROVINER	SLIPPLIER REPRESENTATIVE'S SIGNATU	DE		(X6) DATE

Electronically Signed 07/07/2017

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345332	B. WING		06	C 5/ 15/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895		1 00/13/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	resident and the resident there is when there is- (A) A change in room as specified in §483 (B) A change in resident is state law or regulated (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMENT by: Based on observation and physician interval facility failed to notify prescribed liquid produced in the prescribed liquid produced in the produce	also promptly notify the sident representative, if any, on or roommate assignment (3.10(e)(6); or dent rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and e resident representative(s). It is not met as evidenced ion, staff, Physician Assistant views, and record review, the right is supplement was not two residents sampled iical record revealed Resident (27/2012 with diagnoses of e, low back pain, and sure ulcer of the right ankle. Im Data Set (MDS) dated esident #3 to be severely on and needed extensive ctivities of Daily Living (ADLs) sistance of one to two	F 15	Resident #3 liquid protein was administered by charge nurse on The residents attending physician Responsible Party were notified of doses for the month of June 2017 The facility residents who were id with physician orders for liquid prosupplements were reviewed by the Assistant Director of Nursing to eather that physician orders were being on 6-15-17. Staff Development Coordinator we provide re-education to licensed regarding administration of medic physician orders and actions to be unable to administer medication of	en and of missed	
	noted areas of cond	Area Assessment (CAA) ern about pressure ulcers s, and these areas went to		6-15-17 and will be completed on newly hired licensed nurses will re education during orientation.		

Facility ID: 922992

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
	345332		B. WING		C		
NAME OF PR	ROVIDER OR SUPPLIER	343332	B: Willio	STREET ADDRESS, CITY, STATE, ZIP CODE	l	06/15/2017	
	NTER HEALTH AND REI	JAD.		2501 DOWNING STREET SW			
DIVIAN OL	MILK HEALIH AND KEI	IAD		WILSON, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 157	Continued From page care plan.	2	F 15	57			
	potential for nutritional intake. The goal was significant weight charton the interventions included weight loss, Resident and supplements. On 6/15/2017 at 11:30 Resident #3 did not recome on 6/13/2017, nor did dose of the suppleme 6/15/2017. Nurse #1 she guessed, and significant was none on the stated she did not not stated she did not not supplement on her caresidents scheduled to she would document given and fill out the costation so the supplement on her caresidents scheduled to she would document given and fill out the costation so the supplement on her caresidents scheduled to she would document given and fill out the costation so the supplement was attacked she with the following physician. On 6/15/2017 at 12:00 Nurse #3 stated she with the received liquid protein been one dose on he physician should be resupplement was not gottom in the protein one of the supplement was not gottom in the protein one of the supplement was not gottom in the protein one of the supplement was not gottom in the protein one of the supplement was not gottom in the protein of the protein of the protein one of the protein one of the protein of the protei	noted she was in a hurry, ned the doses as given, but a medication cart. Nurse #1 iffy the physician. 5/2017 at 11:45 AM, Nurse have liquid protein art, that there were three to receive it. Nurse #2 stated the supplement was not order sheet at the nurse ment would be ordered. Would not notify the 0 noon, in an interview, and one resident who in supplement, and there had ar cart. Nurse #3 stated the notified if the liquid given.		Unit Coordinator or Assistant II Nursing will review two sample per unit to ensure that medicat being given per physician orde times four and monthly x two. The results of the audits will be the monthly Quality Assurance meeting monthly for four month review of need for continued m	ed residents cions are ers weekly e brought to Committee hs for		
	facility Administrator s to be ordered in a tim	stated he expected supplies ely manner, and be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345332	B. WING _				C 1 5/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 501 DOWNING STREET SW VILSON, NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 SS=D	In a telephone interviethe Physician Assistal physician stated shew three times weekly arphone. The PA stated not receiving the liquidose was missed, she PA stated if it was mophysician's office sho said "if it is more than notified." 483.21(b)(3)(i) SERV PROFESSIONAL STATE (b)(3) Comprehensive The services provided as outlined by the commust- (i) Meet professional state of the p	ew on 6/15/2017 at 5:35 PM, ant (PA) for Resident #3's was in the facility at least and always available by the in regard to Resident #3 deprotein supplement, if one is thought that was ok. The resident that was ok. The resident that was ok. The rest than one dose, the suid be contacted. The PA one dose, I expect to be a care Plans that was observed and the interview of the presentation of the presentat		281	Resident #3 liquid protein was administered by charge nurse on 6-15-The residents attending physician and Responsible Party were notified of mist doses for the month of June 2017. The facility residents who were identified with physician orders for liquid protein supplements were reviewed by the Assistant Director of Nursing to ensure that physician orders were being follow on 6-15-17.	sed ed	7/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345332			IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			C 06/15/2017		
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2017
				25	501 DOWNING STREET SW		
BRIAN CE	NTER HEALTH AND F	REHAB		W	/ILSON, NC 27895		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From pa	nge 4	F 2	281			
	10/2/2016 noted Reimpaired for cognitic assistance for all A with the physical aspersons. The Care noted areas of contant and nutritional static care plan. The care plan date potential for nutritic intake. The goal was significant weight of the interventions in weight loss, Reside and supplements. In an observation of 6/15/2017 at 9:05 A #3 was supposed the supplement, but the medication cart. Not Resident #3 the other ordered. Nurse #1 liquid protein supplement as not area typed "not avaided not call the phy. A review of the Med (MAR) for June 20 to receive liquid protein supplement as not area typed "not avaid not call the phy.)	am Data Set (MDS) dated esident #3 to be severely on and needed extensive ctivities of Daily Living (ADLs) esistance of one to two Area Assessment (CAA) cern about pressure ulcers as, and these areas went to design 4/10/2017 noted a focus of enal problems related to poor as Resident #3 would have no hanges through next review. Included: due to significant ent #3 receives fortified foods of a medication pass on AM, Nurse #1 stated Resident to get liquid protein nutritional ere was none on the enter was none of the ement in the facility. Nurse #1 not worked for 3 weeks and the of the supplement since she rk. Nurse #1 marked the given and in the explanation aliable". Nurse #1 stated she sician. dication Administration Record 17, revealed Resident #3 was obtain supplement 30 milliliters as daily at 8:00 AM and 6:00 cated Resident #3 had			Staff Development Coordinator will provide re-education to licensed nurses regarding administration of medication physician orders weekly times four and monthly times two. The Unit Coordinator or Assistant Director Nursing will review two sampled residents per unit to ensure that medications are being given per physic orders weekly times four and monthly of two. The results of the audits will be brough the monthly Quality Assurance Commit meeting monthly for four months for review of need for continued monitoring.	per I ctor cian c	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		345332	B. WING				C 15/2017
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			•	STREET ADDRESS, C 2501 DOWNING STR WILSON, NC 2789			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	the AM and PM dose the AM dose on 6/14/2017. The amount of the AM dose on 6/14/2017. The amount of 6/15/2017 at 11:3 Resident #3 did not read on 6/13/2017 and 6/1 was in a hurry, she go doses as given, but the medication cart. Nurse notify the physician. In an interview on 6/1 #2 stated she did not supplement on her mover three residents. Nurse #2 stated she was supplement was not go sheet at the nurses's would be ordered. Nurse #3 stated she would be ordered. Nurse #3 stated she would be received liquid protein been one dose on he stated the supplement company than the phothe ordered. Nurse #3 we was unable to locate stated the physician is supplement was not go the stated the physician is supplement was not go the stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the stated she was unable to locate stated the physician is supplement was not go the physician is the physician is supplement was not go the physician is the ph	sent on 6/13/2017 for both s. Resident #3 had received (2017 and refused the PM (he AM dose on 6/15/2017 er" on the MAR. O AM, Nurse #1 stated eccive the AM supplement 4/2017. Nurse #1 noted she uessed, and signed the nere was none on the e #1 stated she did not 5/2017 at 11:45 AM, Nurse have liquid protein edication cart and there scheduled to receive it. would document the given and fill out the order tation so the supplement arse #2 stated she would not O noon, in an interview, and one resident who in supplement, and there had ar medication cart. Nurse #3 at comes from a different armacy, so it is written on a nurses' station but the order sheet. Nurse #3 should be notified if the liquid	F	281			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345332	B. WING		C 06/15/2017		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895	06/15/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 281	another cart when sh 6/14/2017. Nurse #4 refused the supplement would not document was not given. Nurse	rotein supplement from the worked on 6/13 and stated Resident #3 had tent. Nurse #4 noted she the supplement as given if it the #4 stated there had been ten there was no liquid protein	F 28	31			
	Resident #4 was adn diagnoses of Diabete Disease (PVD) perfo	edical record revealed nitted 7/8/2015 with es, Peripheral Vascular ration of the intestine, and ion of the lining of the					
	1/26/2017 noted Res assessed for cognition problems, either show could perform normal MDS indicated Residually only needed supervisions Living (ADLs) with sec Area Assessment (Company)	n Data Set (MDS) dated bident #4 was unable to be on, but had no memory ret term or long term, and I decision making tasks. The lent #4 was independent or sion for all Activities of Daily et up help only. The Care AA) noted an area of al status and pressure ulcer to care plan.					
	a potential nutritional disease. The goal wa would be maintained significant weight cha Interventions include when needed any sig coughing drooling, an	12/24/2015 noted a focus of problem related to chronic as adequate nutritional status as evidenced by no anges through next review. d: Observe/document/report gns or symptoms of choking, and holding food in mouth. rt to MD any signs of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345332	B. WING _			C 06/15/2017	
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, 2 2501 DOWNING STREET SW WILSON, NC 27895	ZIP CODE	00/13/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIAT CIENCY)		
F 281	Registered Dietician change recommendary change recommendary. A review of the Medic (MAR) for June, 2017 to receive liquid prote (ml) by mouth twice of PM. The MAR indicat receive the liquid sup 6/15/2017 for the AM Resident #4 did receive 6/14/2017 for the PM On 6/15/2017 at 11:3 Resident #4 did not refor the AM dose on 6/15/2017. Nurse #1 she guessed, and sig 6/13/2017, but there cart. Both AM doses as "other "on the MAI documented as not a she did not notify the In an interview on 6/15/2017 to be ordered in a time available for resident orders. The Administrator is liquid protein supplements.	significant weight loss. to evaluate and make diet tions when necessary. Station Administration Record of revealed Resident #4 was sin supplement, 30 milliliters laily at 8:00 AM and 9:00 sed Resident #4 did not plement 6/14/2017 or doses. The MAR indicated we the liquid supplement on dose. O AM, Nurse #1 stated eceive the liquid supplement 1/13/2017, 6/14/2017 and noted she was in a hurry, and the dose as given on was none on the medication (6/14 and 6/15) were noted R and the reason was vailable. Nurse #1 stated physician. 5/2017 at 1:45 PM, the stated he expected supplies sely manner, and be so needs and physician rator noted a quantity of the nent had been found in a		281	IENCY)		
	not remember if he w Resident #4 not rece supplement on 6/14 o	PM in a telephone 4's physician stated he did					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345332	B. WING			C
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP 2501 DOWNING STREET SW WILSON, NC 27895	CODE	06/15/2017
(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 K (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 281	supplement until it is indicated he expects In a telephone intervi the Physician Assista physician stated she three times weekly as phone. The PA stated not receiving the liqui was one dose missed The PA stated if it wa physician's office showhat could be done comething else, or to the resident had miss	will give an order to hold the available. The physician to be notified and usually is. ew on 6/15/2017 at 5:35 PM, ant (PA) for Resident #3's was in the facility at least and always available by d, in regard to Resident #3 id protein supplement, if it d, she thought that was ok. Is more than one dose, the build be contacted to see or to get an order for to get an order for the dose, but had been "if it is more than one dose,"	F2	281		