STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 11/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER SOUTHPOINT	**6000 FAYETTEVILLE ROAD DURHAM, NC 27713**

(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 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		12/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/27/2018

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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F 655	Continued From page 1 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to develop a baseline care plan within 48 hours of admission related to physician's orders and diagnoses for one of four residents reviewed for baseline care plans, Resident #1. The findings included: A review of Resident #1's hospital discharge summary dated 06/17/2018 revealed she was discharged on 06/17/2018 to the facility with the following physician orders related to her colostomy: 1) End colostomy care - Change pouch three times weekly and as needed for leakage, empty when greater than ½ full, and 2) Please provide standard ostomy care. Review of Resident #1's medical record revealed she was admitted to the facility on dated 06/17/2018 with a primary diagnosis at admission of severe sepsis with septic shock and a secondary diagnosis of other specified symptoms and signs involving the digestive system and abdomen. Resident #1's physician's orders revealed the following medications were ordered upon admission to the facility: Warfarin Sodium (anticoagulant) 6 milligrams (mg) by mouth at bedtime for chronic embolism Enoxaparin Sodium Solution (anticoagulant),	F 655	Effective 12/1/18, all newly admitted residents have had a baseline care plan developed within 48 hours. Director of Nursing/Assistant Director of Nursing re-educated all Licensed Nursing Staff on completion of Base Line Care Plans for all new admissions within 48 hours of admission. Education to be completed by 12/4/18. Director of Nursing/Assistant Director of Nursing/Unit Coordinators will audit 5 newly admitted residents utilizing the "Base Line Care Plan Audit Sheet" weekly x 1 month, every 2 weeks x 1 month, monthly x 1 month. Results of audits will be reported to Quality Assurance Process Improvement Committee for review and recommendations monthly x 3.	

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F 655	Continued From page 2	F 655		

100 mg per milliliter (ml), inject 0.9 ml subcutaneously every 12 hours related to chronic embolism and thrombosis

Oxycodone (opioid pain medication) 5 mg tablet, one tablet by mouth as needed for pain

The nursing admission progress note dated 06/17/2018 indicated Resident #1 was admitted to the facility with an admitting diagnosis of chronic embolism. The note was signed by Nurse #2.

The Nursing Admission Data Collection form dated 06/17/18 indicated in section K. 1.d that Resident #1 had a colostomy.
A review of Resident #1's closed record from her facility stay between 06/17/18 and 06/25/2018 revealed there was no baseline (interim) care plan present to address her use of anticoagulants, colostomy care, or pain.

The Minimum Data Set (MDS) discharge assessment dated 06/25/2018 revealed Resident #1 was fully cognitively intact, she had an ostomy, and that she received opioid pain medication and anticoagulants.

In a phone interview with Resident #1 on 11/08/17 at 1:58 PM, she stated her colostomy was created during surgery at the hospital in May 2018. Resident #1 stated she was admitted to the facility on 06/17/18 and she did not feel comfortable with her colostomy care since it was new to her. She also stated her colostomy often leaked while she was in the facility and she did not want her abdominal surgical wound to become infected from bowel leakage. Resident #1 added that she was taking pain medication and anticoagulants as part of her rehabilitation

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from her surgery. In a follow up phone interview with Resident #1 on 11/09/18 at 3:32 PM, she stated she did not receive a baseline plan of care during her 8-day stay at the facility.

In an interview with the MDS nurse on 11/08/2018 at 2:27 PM, she stated that a new admission should have an interim or baseline care plan, but it was not initiated by the MDS nurses. The MDS nurse stated she was not certain who would initiate an interim care plan prior to the comprehensive care plan. The MDS nurse added if a resident had a colostomy or was taking anticoagulants, then she would expect these problems to be addressed in a nursing care plan. She also indicated that short term residents were not present in the facility long enough to have a comprehensive care plan completed.

In a phone interview with Nurse #1 on 11/08/2018 at 3:27 PM, she stated she was assigned to care for Resident #1 on the day she entered the facility. Nurse #1 stated she did not know who initiated baseline care plans for new residents and she did not recall having one for Resident #1.

In an interview with the Director of Nursing (DON) on 11/08/2018 at 2:45 PM, she stated she was not aware that a baseline or interim care plan was needed within 48 hours of admission since the nurses carried out physician orders for the short term residents. The DON stated all nurses on staff were trained regarding colostomy care and other care related to Resident #1's diagnoses.