	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(- /	ATE SURVEY DMPLETED
			A. BUILDIN			С
		345343	B. WING			12/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
		HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE	E	
	INTER HEALTH AND RE	HABILITATION/GOLDSBORG		GOLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JENCY)	(X5) COMPLETION DATE
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ients	F 6	41		1/11/19
	resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) asse classification of a me sampled residents re assessments (Reside approaches provided residents reviewed for assessments (Reside The findings includeo 1) Resident #105 was 11/5/18 from a hospit diagnoses included a (stroke). A review of the reside medication orders inc clopidogrel (an antipl given as one tablet b A review of Resident	at accurately reflect the is not met as evidenced iew and staff interviews, the ately code the Minimum assments for: 1) the dication received by 1 of 27 viewed for the accuracy of ent #105); and, 2) nutritional for 1 of 27 sampled or the accuracy of ent #36). : s admitted to the facility on al. Her cumulative history of cerebral infarction ent ' s 11/5/18 admission cluded 75 milligrams (mg) atelet medication) to be		Resident #105 MDS w transmitted on 12/14/18 MDS was modified and 12/14/18. All current resident's or residents on Plavix the were audited on 12/14/ that required modification anticoagulant due to Pl were modified and tran All current resident's wh fluids the previous 90 d on 12/14/18 and all MD modification to reflect a of IV medications were transmitted. In-servicing by the resid management director w the MDS coordinators of In-service included to n (clopidogrel) as an anti-	 B. Resident #36 B. Resident #36 B. Itransmitted on A. Plavix and all previous 90 days (18 and all MDS') (19 and all MDS') <l< td=""><td></td></l<>	
	completed. Section N of the MDS indicated the resident received an anticoagulant medication on 7 out of 7 days during the look back period.			an anti-platelet medicat coding of IV medication Resident care manager	ns in the MDS.	
	PM with MDS Coordi	oordinator reported she had		designee will audit all re (clopidogrel) weekly tim monthly times two begi ensure that Plavix is no	esidents on Plavix nes four then nning on 1/2/19 to	

Electronically Signed

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.

01/09/2019

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	· ,	3	COMF	PLETED
		345343	B. WING			С
	ROVIDER OR SUPPLIER	345343	B. WING	STREET ADDRESS, CITY, STATE, ZIP		/14/2018
NAME OF P	ROVIDER OR SUPPLIER			1700 WAYNE MEMORIAL DRIVE	CODE	
BRIAN CE	ENTER HEALTH AND RE	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From page	a 1	F 64	1		
1 011		viewed Section N of the	F 04	anticoagulant. Resident c	are	
		firmed this MDS indicated		management director or o		
		an anticoagulant medication		audit all residents who re	-	
	on 7 out of 7 days du	ring the look back period.		weekly times four then me		
		reported she would have		beginning on 1/3/19 to en		
		an anticoagulant. However,		coding of received IV fluid	ds in the MDS.	
		stated she needed to check				
		re MDS Director as to		The resident care manage designee will report audit		
	whether or not this wa	as coded correctly.		facility Quality Assurance		
	An interview was con	ducted on 12/14/18 at 10:54		Performance Improvement		
		s Resident Care MDS		weekly times four and mo		
	-	the coding of clopidogrel as		The committee will evalua		
	an anticoagulant on F	Resident #105's MDS		and implement additional	interventions as	
	-	the interview, the MDS		needed to ensure continu	ied compliance.	
		opidogrel should not have				
		ticoagulant. She reported sion MDS had been coded				
		this assessment has now				
	been corrected.					
		iducted on 12/14/18 at 2:06 Director of Nursing (DON).				
		the coding of the residents '				
		ere discussed. The DON				
	reported she was told	d about the concerns				
		ding of the assessments.				
		ctation would be, "For the				
	MDS coding to be do fully educated on hov	ne correctly and that we are v to code the MDS."				
	2) Resident #36 was	admitted on 9/18/17 with				
		on 11/8/17 from a hospital.				
	Her cumulative diagn non-Alzheimer 's der					
	A review of Resident	#36 ' s quarterly Minimum				
		essment dated 10/29/18 was				
		K of the MDS indicated				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/06/2019 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345343	B. WING _				C /14/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRECTION	1	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	K	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 641	feeding while a reside last 7 days. However s medical record reve documentation to ind parenteral/intravenou resident in the facility 10/29/18.	d parenteral/intravenous ent in the facility within the r, a review of Resident #36 '	F6	94 1			
	PM with MDS Coordi interview, the MDS C completed Resident # assessment dated 10 Section K of the asse MDS indicated the re parenteral/intravenou resident in the facility MDS Coordinator #1 review the resident's	nator #1. During the oordinator reported she had #36 ' s quarterly MDS 0/29/18. She reviewed sssment and confirmed this					
	AM with the facility 's Director in regards to Resident #36's MDS interview, the Directo assessment had alreat that no parenteral/intr provided to Resident back period while she further inquiry, the MI	the coding of Section K on assessment. During the r reported the 10/29/18 MDS ady been corrected to reflect					
	PM with the facility's	ducted on 12/14/18 at 2:06 Director of Nursing (DON). the coding of the residents '					

TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345343	B. WING			C 2/14/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		2/14/2010
				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NTER HEALTH AND RE	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	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 3	F 6	641		
	reported she was told identified with the coo her expectation would	ding of the MDS. She stated d be, "For the MDS coding to d that we are fully educated				
F 759 SS=D		rror Rts 5 Prcnt or More	F 7	/59		1/11/19
	§483.45(f) Medication The facility must ensu					
	percent or greater;	tion error rates are not 5 is not met as evidenced				
	Based on observation record review, the fact medication error rate evidenced by 2 medic medication opportuni medication error rate	of less than 5% as cation errors out of 26 ties, resulting in a of 7.6% for 2 of 5 residents esident #68) observed		Resident # 68 was assu 12/12/2018 by the Direct signs and symptoms of thrush). The attending notified on 12/12/2018 t not have any signs of fur mouth.	ctor of Nursing for fungus infection (physician was hat resident did ingus infection in	
		: admitted to the facility on ative diagnoses which		Resident #77 physician regarding combivent inh properly being primed; r received.	aler used without	
	included chronic obst A review of Resident Orders included a cur micrograms (mcg) / a Respimat to be admin four times daily (initia Respimat is an inhale combination of two m	#77 's active Physician rrrent order for 20/100 activation of Combivent histered as one inhalation ted 9/19/18). Combivent ed medication containing a hedications, ipratropium and or the management of		The facility licensed nur medication aids will be education regarding prin inhaler, to include man recommendations regar new the inhaler by the coordinator or designee licensed nurses and me be provided re- educatio	provided re- ming of Combivent ufacture rding priming of a Staff development . The facility edication aids will	

Facility ID: 922984

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345343	B. WING				C /14/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO		170	00 WAYNE MEMORIAL DRIVE		
				GC	DLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 759	Continued From page	e 4	F 7	59			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 chronic obstructive pulmonary disease. On 12/12/18 at 4:26 PM, Medication Aide (Med Aide) #1 was observed as she prepared to administer 20/100 mcg Combivent Respimat to Resident #77. The med aide opened a box containing a new 20/100 mcg Combivent Respimat inhaler. After she inserted the cartridge into the delivery mouthpiece, she primed the system by depressing the actuator one time only; a fine mist (spray) was observed at that time. The Combivent Respimat inhaler was brought to Resident #77 and one puff of the medication was administered. A review of the manufacturer 's instructions on the preparation for use and priming of the Combivent Respimat inhaler was conducted. These instructions read, in part: "Instruct patients that priming Combivent Respimat is essential to ensure appropriate content of the medication in each actuation. When using the unit for the first time, the Combivent Respimat cartridge is inserted into the Combivent Respimat inhaler and the unit is primed. Combivent Respimat are to actuate the inhaler toward the ground until an aerosol cloud is visible and then repeat the process three more times. The unit is then considered primed and ready for use." An interview was conducted on 12/12/18 at 4:45 PM with Med Aide #1. During the interview, the manufacturer 's instructions were taken out of the Combivent Respimat inhaler 's box and the directions for priming the inhaler were reviewed.		F 7	59	of Symbicort inhaler , to include rinsing the mouth with water and not shallow after use by the staff development coordinator or designee. Any licensed nurses and/or medication aid that doe not receive the re- education will recei- prior to working the their next schedule shift. The facility newly hired licensed nurses or medication aids will received the education during orientation The facility staff development coordina and / clinical manager (Director of Nursing, Assist Director of Nursing an unit coordinator) will complete two medication observation weekly times f bi monthly times two , to ensure that in Combivent inhalers are primed per manufacture recommendation prior to use and Symbicort inhalers are administrator and resident mouth rinse per recommendations. The Facility Director of Nursing will rep findings to QAPI monthly times three. QAPI will review and analyze the findi to determine if further action is needed	ng s ve ed d ator d four, new o cour, new o court The ng	

Facility ID: 922984

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/06/2019 RM APPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345343	B. WING			C 12/14/2018		
NAME OF P	ROVIDER OR SUPPLIER	l		STF	REET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO		170	0 WAYNE MEMORIAL DRIVE			
	· · · · · · · · · · · · · · · · · · ·		1	GC	DLDSBORO, NC 27534		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 759	three more times in o An interview was com PM with the facility 's During the interview, expectation was for h to know how to admir were giving. The DO expect for them to rea have the knowledge f medications properly. 2) Resident #68 was 3/17/14 with a cumula included chronic obst A review of Resident Orders included a cum (mcg) / 4.5 mcg Syml two puffs inhaled two 6/22/18). The physic following instructions, after use. Do not swa inhaled medication co two medications, bud formoterol. It is used asthma and/or chroni disease. On 12/12/18 at 8:25 / as she prepared and Resident #68. The m administration include Symbicort. The resid inhaled two puffs of th nurse did not prompt mouth out with water	acturer 's directions a needed to be repeated rder to prime the inhaler. ducted on 12/13/18 at 3:16 a Director of Nursing (DON). the DON reported her er nurses (and med aides) hister the medications they N also stated she would ceive the education and to administer the admitted to the facility on ative diagnoses which ructive pulmonary disease. #68 's active Physician frent order for 80 microgram bicort to be administered as times a day (initiated ian 's order included the , "Rinse mouth with water allow." Symbicort is an ontaining a combination of esonide (a steroid) and for the management of c obstructive pulmonary	F	759				

Facility ID: 922984

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345343	B. WING				C 14/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 759	Continued From page	9 6	F	759			
	included the following in part: "Symbicort sh inhalations twice daily approximately 12 hou orally inhaled route or patient should rinse th swallowing." Addition Guide (Revised 12/20 the following administ your mouth with wate each dose (2 puffs) o the water. This will he getting a fungus infect and throat." An interview was con AM with Nurse #1. D	hbicort (Revised 12/2017) Administration Information, nould be administered as 2 (morning and evening, urs apart), every day by the hly. After inhalation, the ne mouth with water without hally, the Patient Information 017) for Symbicort specified tration guidelines: "Rinse r and spit the water out after f Symbicort. Do not swallow elp to lessen the chance of tion (thrush) in the mouth ducted on 12/12/18 at 8:45 uring the interview, the					
	instruction to Resider	did not provide water or at #68 to rinse her mouth the Symbicort inhaler.					
F 761	PM with the facility 's During the interview, expectation was for h to know how to admir were giving. The DO		F	761			1/11/19
SS=D		(1)(2) of Drugs and Biologicals s used in the facility must be					

Facility ID: 922984

If continuation sheet Page 7 of 16

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/06/2019 1 APPROVEE 0. 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345343	B. WING			C 12/14/2018		
NAME OF P	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
BRIAN C	ENTER HEALTH AND RE	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In acco Federal laws, the fact biologicals in locked temperature controls, personnel to have acc §483.45(h)(2) The fact locked, permanently storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribut quantity stored is mint be readily detected. This REQUIREMENT by: Based on observation record review, the fact expired medications of observed (200 West medication carts Cart); and, 3) failed to specified by the mant medication carts obset and 200 West Med C The findings included	e with currently accepted s, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and difty must store all drugs and compartments under proper , and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can is not met as evidenced ans, staff interviews, and cility: 1) failed to remove from 1 of 3 medication carts Med Cart); 2) failed to label nortened expiration date in 1 observed (200 West Med to store medications as ufacturer in 2 of 3 erved (100 Hall Med Cart art).	F	761	Nurse #1 removed and discarded 0.005% Latanoprost ophthalmic soluti from the 200 West cart on 12/12/2018 Nurse #1 removed and discarded Novolog flexpen that was dispensed of 11/6/18 for Resident #62 0n 12/12/20 Nurse # 1 removed and discarded budesonide inhalation suspension vial was observed stored outside of the for pouch without date on 200 West cart 12/12/2018.	n 18. that		

Event ID: LM3D11

Facility ID: 922984

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
		245242				С
		345343				12/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE 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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	Continued From page	e 8	F 76	1		
		ication Cart was conducted	170	Nurse #1 removed and disc	arded	
	on 12/12/18 at 8:17 A			Latanoprost eye drops that		
		pottle of 0.005 % latanoprost		12/12/18 stored unopened		
		an eye drop medication used		cart verses per manufactur		
		beled for Resident #57 was		recommendation of refrigera		
		hand-written notation on the		open.		
	bottle indicated the la	intanoprost eye drops were				
		n auxiliary label placed on		Nurse #2 removed and disc	carded 5%	
	the lantanoprost eye	drop bottle by the pharmacy		Xiidra ophthalmic solution th	nat was	
	read, "Refrigerate uni	til opened. Discard 6 weeks		observed on 12/13/18 sotre	d outside the	
	after opening." Nurse	e #1 confirmed both the date		foil pack without date on 12	/12/2018.	
	the latanoprost bottle	noprost bottle was opened and the				
		macy auxiliary sticker which		The facility Director of Nursi	ng completed	
	-	bottle of latanoprost had a		an audit for all medication c		
	-	date. Based on date the		medication refrigerators to e		
		opened, the shortened		Xiidra, Latanoprost eye drop		
	expiration date of the	eye drops was 10/16/18.		inhalation suspension and N	-	
		e		flexpen were stored per ma		
	A review of the manu			pharmacy recommendation		
		prost ophthalmic solution				
	-	ed, the container may be		The licensed nurses and me		
		erature up to 25o C (77o F)		will be provided re- education		
	for 6 weeks.			storage and labeling of med staff development coordinat		
	A roviow of Posidont	#57 's current Physician		licensed nurses and/or med	•	
		e was a current order for		does not receive the re- edu		
		e was a current order for eye drops to be instilled as		receive it prior to working the		
	one drop in each eye			scheduled shift. The facility		
				licensed nurses or medicati		
	An interview was con	ducted on 12/13/18 at 2:45		received the education durin		
		Birector of Nursing (DON).			0	
		the DON reported her		The director of nursing or de	esignee will	
	-	Ill medications to be dated		complete 1		
		hen they were opened and		observations weekly times f		
		xpiration date, as well. She		monthly times two to ensure		
		dication needed to be		are stored and labeled per		
	disposed of or sent b			recommendations to include		
		-		Latanoprost eye drops, bud	esonide	
	1 b) Accompanied by	y Nurse #1, an observation		inhalation suspension and N		

Facility ID: 922984

If continuation sheet Page 9 of 16

		MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SU	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLE	
					С	
		345343	B. WING		12/14	\$/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE 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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 761	Continued From page	e 9	F 76	1		
		ication Cart was conducted		flexpen.		
	on 12/12/18 at 8:17 A revealed an opened l			The Facility Director of Nur	rsing will report	
		lispensed by the pharmacy		findings to QAPI weekly tin		
		ed for Resident #62 was		then monthly times three.		
		tion cart. A hand-written log Flexpen appeared to		review and analyze the find determine if further action i		
		opened on 11/1/18 (which			is needed.	
		sulin 's shortened expiration				
		Nurse #1 was asked to				
		and-written date to help was possibly opened on				
	-	indicate the insulin expired				
		er, Nurse #1 stated the				
	insulin pen appeared opened on 11/1/18.	to be dated as having been				
	A review of the manu					
	instructions for a Nov in use, the insulin per	olog Flexpen indicated once				
	-	an 30o C (86o F) and used				
	within 28 days.					
		#62 ' s current Physician				
	Orders revealed there Novolog insulin to be	e was a current order for				
		er the skin) three times a				
	day before meals.					
		ducted on 12/13/18 at 2:45				
		Director of Nursing (DON).				
	-	the DON reported her Ill medications to be dated				
	-	hen they were opened and				
	when there was an e	xpiration date, as well. She				
	· ·	dication needed to be				
	aisposed of or sent b	ack to the pharmacy.				
			1	i i i i i i i i i i i i i i i i i i i		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/06/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		STRUCTION	(X3) DATE COM	E SURVEY PLETED
		345343	B. WING			C 12/14/2018	
	ROVIDER OR SUPPLIER	HABILITATION/GOLDSBORO	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534				
(X4) ID PREFIX TAG			ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 761	12/12/18 at 8:17 AM. box of 0.25 milligram budesonide inhalation inhaled steroid medic of asthma or chronic disease) dispensed fi 11/7/18 for Resident is cart. The box contain pouch with 4 vials of vials of budesonide in stored in the box outs was no empty foil pour confirmed the observ budesonide inhalation the undated foil pour without a foil pouch. A review of the manue instructions for budes indicated once the all opened, the solution weeks. A review of Resident Orders revealed them 0.25 mg/2ml budeson administered as one times a day. An interview was com PM with the facility 's During the interview, a foil pouch for inhala medication needed to pouch. She also stat all medications to be when they were oper	tion Cart was conducted on The observation revealed a s (mg) / 2 milliliters (ml) n suspension vials (an cation used in the treatment obstructive pulmonary rom the pharmacy on #61 was stored on the med hed one opened, undated foil budesonide. Five additional nhalation suspension were side of a foil pouch (there uch in the box). Nurse #1 red storage of the n suspension vials inside of h and the vials stored facturer 's storage sonide inhalation suspension uminum package was should be used within 2 #61 's current Physician e was a current order for hide suspension to be inhalation via nebulizer two aducted on 12/13/18 at 2:45 s Director of Nursing (DON). the DON reported if there is	F7	761			

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/06/2019 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345343	B. WING			(12/*	; 14/2018
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
BRIAN CE	NTER HEALTH AND REF	ABILITATION/GOLDSBORO		700 WAYNE MEMORIAL DRIVE OLDSBORO, NC 27534	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 761	Continued From page medication needed to back to the pharmacy 3-a) Accompanied by and joined by Nurse # Hall Medication Cart v at 9:30 AM. The obse of 0.5 milligram (mg)-/ ipratropium/albuterol i inhaled medication us chronic obstructive pu stored outside of the f of a manufacturer ' s is cart. A review of the manufi instructions for ipratro solution indicated vial light before use. Unus the foil pouch for stora An interview was cond PM with the facility ' s During the interview, fa a foil pouch for inhalar medication needed to pouch. 3-b) Accompanied by and joined by Nurse # Hall Medication Cart v at 9:30 AM. The obse single-use containers solution (an eye medi disease) were lying out	e 11 be disposed of or sent the facility's Administrator t2, an observation of the 100 was conducted on 12/12/18 ervation revealed two vials 2.5 mg / 3 milliliter (ml) inhalation solution (an sed for the management of almonary disease) were foil pouch and placed on top box inside the medication facturer 's storage opium/albuterol inhalation s should be protected from sed vials should be placed in age. ducted on 12/13/18 at 2:45 Director of Nursing (DON). the DON reported if there is tion solutions, the be stored inside of that foil the facility's Administrator t2, an observation of the 100 was conducted on 12/12/18	F 761				
	having been dispense	c solution was labeled as ed for Resident #34.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	0. 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345343	B. WING			1:	C 2/14/2018
NAME OF P	ROVIDER OR SUPPLIER	I		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND REI	HABILITATION/GOLDSBORO			1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761	According to the prod single-use containers in the original foil pour A review of Resident Orders revealed there Xiidra ophthalmic solud drop in both eyes one An interview was con PM with the facility 's During the interview, a foil pouch, the medi inside of that foil pour 3-c) Accompanied by the 200 West Medica 12/12/18 at 8:17 AM. an unopened bottle o ophthalmic solution (a to treat glaucoma) lat stored on the cart. Th latanoprost bottle indii from the pharmacy or auxiliary sticker place "Refrigerate until ope opening." A review of the manuf instructions for latano intact (unopened) bot refrigeration at 20 Ce Fahrenheit (F) to 460 An interview was con PM with the facility 's During the interview, expected medications	luct manufacturer, of Xiidra should be stored ch. #34 ' s current Physician e was a current order for 5% ution to be instilled as one e time a day. ducted on 12/13/18 at 2:45 b Director of Nursing (DON). the DON reported if there is idation needed to be stored ch. Nurse #1, an observation of tion Cart was conducted on The observation revealed f 0.005 % latanoprost an eye drop medication used beled for Resident #58 was ne labeling on the idated it had been dispensed in 12/6/18. A pharmacy ed on the latanoprost read, ned. Discard 6 weeks after	F	761			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING			C 12/14/2018			
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534			1 12/14/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 761 F 867 SS=D	refrigerator when they QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The quassurance committee (ii) Develop and imple action to correct idem This REQUIREMENT by: FACILITY QAA and QAPI Based on staff intervi facility's Quality Asse Committee failed to m procedures and moni committee put into pla recertification survey for one deficiency wh recertification survey continued failure of th surveys of record sho inability to sustain an Assessment and Ass The findings included This citation is cross on observations, reco- interviews the facility expired medications for observed (200 West	y were needed. tent Activities (ii) assessment and assurance. Hality assessment and e must: ement appropriate plans of tified quality deficiencies; T is not met as evidenced ew and record review, the ssment and Assurance naintain implemented tor the interventions the ace following the of 01/12/2018. This was ich was recited during the of 12/14/2018 in F761. The he facility during two federal bws a pattern of the facility's effective Quality urance program. I: referenced to: F761 Based		761	The facility QAPI team to include the Administrator , Director of Nursing, Uni managers, Social Worker, Rehab Manager and Dietary Manager were provided re- education regarding the Quality Assurance and Performance Improvement process by district clinica Director. Nurse #1 removed and discarded 0.005% Latanoprost ophthalmic solutio from the 200 West cart on 12/12/2018. Nurse #1 removed and discarded Novolog flexpen that was dispensed ou 11/6/18 for Resident #62 On 12/12/207 Nurse # 1 removed and discarded budesonide inhalation suspension vial was observed stored outside of the for pouch without date on 200 West cart 12/12/2018. Nurse #1 removed and discarded	al on 18. that il	1/11/19	
	of 3 medication carts	observed (200 West Med o store medications as			Latanoprost eye drops that observed of 12/12/18 stored unopened in medicat			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	02/06/2019 1 APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345343		(X1) PROVIDER/SUPPLIER/CLIA	1 ' <i>'</i>	E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
		B. WING		C 12/14/2018			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
		HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE			
	INTER HEALTH AND RE	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 867	and 200 West Med C From the previous su facility failed to dispo On 12/14/18 at 4:30 acknowledged under the repeated deficien recertification survey	ufacturer in 2 of 3 erved (100 Hall Med Cart Cart). urvey of 01/12/2018, the se of expired medications. PM the Administrator standing of the reciting of icy F761 from the of 01/12/2018. The he was aware of medication hey were addressing	F 867	 7 cart verses per manufacture recommendation of refrigeration open. Nurse #2 removed and discard Xiidra ophthalmic solution that to observed on 12/13/18 sotred of foil pack without date on 12/12/ 7 The facility Director of Nursing an audit for all medication cart medication refrigerators to ensu Xiidra, Latanoprost eye drops, inhalation suspension and Nov flexpen were stored per manufa pharmacy recommendation. 7 The licensed nurses and medication cordinator. 8 The licensed nurses and medication storage and labeling of medicari staff development coordinator. 9 Licensed nurses and/or medicari staff development coordinator. 9 Licensed nurses or medication at receive it prior to working the the scheduled shift. The facility new licensed nurses or medication at received the education during of the director of nursing or design complete 1 □ 2 medication carf observations weekly times four monthly times two to ensure mare stored and labeled per mare stored and labele	ded 5% was utside the /2018. completed and ure that budesonide olog acture and cation aids on the tion by the Any tion aid that tion will heir next wly hired aids will orientation. gnee will t and bi □ hedications nufacture iidra, onide		
				flexpen. The Facility Director of Nursing	will report		
	7(02-99) Previous Versions Ob	solete Event ID: I M3D?		acility ID: 922984	If continuation sheet	D 45 . 640	

Event ID: LM3D11

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		ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 02/06/2019 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345343	B. WING		1	C 2/14/2018	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		2/14/2010	
				1700 WAYNE MEMORIAL DRIVE			
BRIAN CE	NIER HEALIH AND REI	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From page	e 15	F	367 findings to QAPI weekly then monthly times three review and analyze the fi determine if further action	times four and . The QAPI will inding to		
	7(02-99) Previous Versions Obs	olete Event ID: I M		Facility ID: 922984		eet Page 16 of 16	

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