STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 9/30/2019 through 10/4/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 85QF11.	E 000		
F 000	INITIAL COMMENTS 1 of the 4 complaint allegations were substantiated resulting in deficiencies. The survey team entered the facility on 9/30/19 to conduct a recertification and complaint investigation survey and exited on 10/4/19. Additional information was obtained on 10/11/19. Therefore, the exit date was changed to 10/11/19.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the areas of wander alarms, medications, anticoagulant use, catheter use, and pressure ulcers for 6 of 18 residents reviewed for MDS accuracy (Resident #25, Resident #32, Resident #11, Resident #31, Resident #44, and Resident #33). Findings included: 1. Resident #25 was admitted to the facility on 9/19/14 with diagnoses that included diabetes	F 641	F 641 E Facility failed to accurately code the Minimum Data Set for the areas of wander alarms, medications, anticoagulant use, catheter use and pressure ulcers for 6 of 18 residents reviewed for MDS accuracy. (Resident #25, Resident #32, Resident #11, Resident #31, Resident #44 and Resident # 33) Resident #25 MDS assessment dated 8/14/19, Quarterly assessment, documentation reviewed during look back period. MDS assessment ARD 8/14/19	11/8/19

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

Electronically Signed | 11/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 641	Continued From page 1 mellitus and hypertension. A physician's order dated 7/20/19 revealed an order for the use of a wander alarm. Resident #25's MDS assessment dated 8/14/19, coded as a quarterly assessment specified no wander alarms were used during the look back period. The August 2019 Treatment Administration Record revealed the battery on the wander alarm was checked nightly for function and placement. An observation conducted on 10/1/19 at 2:46 PM noted a wander alarm on Resident #25's right wrist. During an interview on 10/3/19 at 4:30 PM MDS Coordinator #2 stated the assessment conducted 8/14/19 should have reflected the use of a wander alarm. During an interview on 10/4/19 at 11:03 AM the Administrator stated the assessment should have reflected the use of a wander alarm. 2. Resident #32 was admitted to the facility on 2/4/15 with diagnoses that included hypertension and chronic pain. Resident #32's MDS assessment dated 8/21/19, a quarterly assessment revealed she was assessed in Section N, question N0410 as receiving an antibiotic, anticoagulant, hypnotic, and diuretic daily during the 7-day lookback period. The August 2019 Treatment Administration	F 641	was modified on 10/1/19 to reflect P0200e wander/elopement alarm was used daily. Resident # 32 MDS assessment dated 8/21/19 modification was completed on 10/23/19 to reflect that resident did not receive antibiotic, anticoagulant, hypnotic or diuretic in the look back period. Resident #11 MDS assessment dated 7/18/19, was modified on 10/24/19 to accurately reflect N0410 as not receiving anticoagulant during the 7 day look back period. Resident #31 MDS assessment dated 8/21/19 was modified on 10/2/19 to accurately reflect H0100D as resident did not receive intermittent catheterization. Resident #44 MDS assessment dated 8/26/19, was modified on 10/3/19 to accurately reflect that Resident # 44 had four pressure ulcers. Resident #33, MDS assessment dated 8/23/19 was modified on 10/4/19 to reflect presence of stage two pressure ulcer that was not present upon admission/re-entry. District Director of Care Management and Area MDS RN Coordinator conducted in-service with Facility Administrator, Director of Nursing, MDS Coordinator, Activity Director, Director of Rehab and Social Services Director in relation to MDS accuracy and Coordination of assessment. Also, DDCM and RN MDS Coordinator discussed timely completion of interviews and expectation to validate completion. In-service completed on 10/28/19. District Director of Care Management and Area MDS RN Coordinator will review current residents with OBRA Admission,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 641	Continued From page 2 Record revealed no administration of an antibiotic, anticoagulant, hypnotic or diuretic during the lookback period for Resident #32. During an interview on 10/3/19 at 4:30 PM MDS Coordinator #1 stated she made an error in coding the assessment and Resident #32 did not receive any antibiotics, anticoagulants, hypnotics, or diuretics during the 7-day lookback period of the assessment. During an interview with the Administrator on 10/4/19 at 11:03 AM she indicated Resident #32's assessment should have been coded correctly for medications. 3. Resident #11 was admitted to the facility on 7/11/19 with diagnoses that included diabetes mellitus and hypertension. Resident #11's MDS assessment dated 7/18/19, an admission assessment revealed he was assessed in Section N, question N0410 as receiving an anticoagulant during the 7-day look back period. The July 2019 Treatment Administration Record revealed no administration of an anticoagulant during the lookback period for Resident #11. During an interview on 10/3/19 at 4:30 PM MDS Coordinator #1 stated administration of an anticoagulant was a coding error. She stated anticoagulants should have not been coded on Resident #11's assessment. During an interview with the Administrator on 10/4/19 at 11:03 AM she indicated Resident #11's assessment should have been coded correctly for	F 641	Annual, SCSA and Quarterly assessments completed and transmitted per Assessment History Report from 9/1/19 to 10/27/19 for accuracy of coding of wander alarms, medication, anticoagulant use, catheter use and pressure ulcer coding. Assessments with errors identified will be corrected as appropriate by the MDS Coordinator. Audit will be completed by 11/8/2019. The District Director of Care Management is responsible for oversight and monitoring of 5 sample resident's weekly times four weeks and then 5 residents monthly for 2 months to review MDS accuracy of diagnosis coding and wandering. Results of the monitoring will be taken to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 641	Continued From page 3	F 641		

medications.

2. Resident #31 was admitted to the facility on 6/21/19 with diagnoses including neurogenic (dysfunctional) bladder and urine retention.

Review of a care plan for Resident #31 dated 6/24/19 indicated a focus area of indwelling catheter for diagnosis of neurogenic bladder with a goal of will be free from catheter related trauma and interventions including anchor catheter to prevent excess tension.

Review of a quarterly Minimum Data Set (MDS) assessment for Resident #31 dated 8/21/19 was coded to indicate Resident #31 had both an indwelling bladder catheter and received intermittent bladder catheterization.

On 10/2/19 at 4:05 PM interview with the facility MDS Coordinator indicated Resident #31 did not receive intermittent bladder catheterization. She further indicated this was an error in coding and would be corrected.

On 10/3/19 at 1:42 PM interview with the facility Administrator indicated MDS assessments should be completed accurately.

3. Resident # 44 was admitted to the facility on 8/13/2019 with diagnoses which included pressure ulcer of the sacral region (stage four).

The care plan dated 8/13/2019 focused on a plan for Resident #44 that specified the resident had a stage four pressure ulcer to the sacrum, stage three ulcer to left ankle, stage two ulcers to left ischium and left heel with interventions to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 641	Continued From page 4	F 641		

administer treatments as ordered.

An Admission Minimum Data Set (MDS) dated 8/26/2019 revealed Resident # 44 had a stage four pressure ulcer to the sacral area.

An interview with the Treatment Nurse on 10/3/2019 at 2:00 pm revealed Resident # 44 was admitted to the facility on 8/13/2019 with four pressure ulcers.

During an interview with the MDS coordinator #2 on 10/3/2019 at 8:42 am, he stated Resident's #44 admission-MDS of 8/26/2019 the MDS was incorrect because it specified the resident only had one pressure ulcer and it should have specified the resident had a total of four pressure ulcers. MDS Coordinator #2 stated the resident's MDS would be modified.

On 10/4/2019 at 11:07 am during an interview with the Administrator, she stated the MDS should have been marked to reflect the correct number of pressure ulcers that the resident had upon admission.

4. Resident # 33 was admitted to the facility on 6/18/2019 with diagnoses which included type two diabetes, alzheimer disease and cerebral infarction.

A Minimum Data Set (MDS) dated 8/23/2019 revealed Resident # 33 had no pressure ulcers.

A daily nursing note dated 8/23/2019 revealed Resident # 33 had an open area to the right side of the foot which measured in length two centimeters by one centimeter in width with no drainage noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 641	Continued From page 5 The interview with the Treatment Nurse on 10/3/2019 at 3:00 pm revealed the resident had an open area to the right foot that was receiving daily treatments. On 10/3/2019 during an interview with MDS Coordinator #1, it was revealed that Resident # 33's open area on the right foot she assessed on 8/23/2019 and the area on the heel was observed to be open. MDS Coordinator #1 also stated the open area should have been marked as a pressure ulcer stage two on Resident # 33's 8/23/2019 MDS. On 10/4/2019 at 11:07 am during an interview with the Administrator, she indicated the MDS should have been marked to reflect any pressure ulcers that were present.	F 641		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly-	F 642		11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 642	Continued From page 6 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a quarterly Minimum Data Set (MDS) assessment before the assessment was submitted to the national data base for 1 of 20 sampled residents reviewed for resident assessments. (Resident #38) Findings included: Resident #38 was admitted to the facility on 5/3/18 with diagnoses including insomnia, anxiety disorder and depression. Review of the quarterly MDS assessment for Resident #38 dated 9/4/19 indicated her mood interview had not been assessed. Further review of the quarterly MDS assessment for Resident #38 dated 9/4/19 revealed it was signed as complete by the facility's MDS Coordinator on 9/10/19 and had been submitted to the national data base. On 10/3/19 at 1:25 PM interview with the MDS Coordinator indicated the facility Social Worker was responsible for the mood interview section of the quarterly MDS assessment dated 9/4/19 for	F 642	F 642 D Facility failed to complete a Quarterly MDS assessment before the assessment was submitted to the national data base for 1 of 20 sampled residents. (Resident #38) Review of quarterly assessment Resident #38 dated 9/4/19 indicated that her mood interview had not been assessed. Further review of quarterly MDS assessment for Resident #38 revealed it was signed as complete on 9/10/19 by the facility MDS Coordinator and submitted to the data base. District Director of Care Management and Area MDS RN Coordinator conducted in-service with Facility Administrator, Director of Nursing, MDS Coordinator, Activity Director, Director of Rehab and Social Services Director in relation to MDS accuracy and Coordination of assessment. Also, District Director of Care Management and RN MDS Coordinator discussed timely completion of interviews and expectation to validate interview are completed timely. In-service completed on 10/28/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 642	Continued From page 7 Resident #38. On 10/3/19 at 1:27 PM in an interview, the facility Social Worker stated she had been out on leave during the assessment period for Resident #38's quarterly MDS assessment dated 9/4/19 and had been told on her return she was not able to go back and assess the mood interview as it was past the assessment reference date. She further indicated she coded the section as not assessed. On 10/3/19 at 1:42 PM an interview with the facility Administrator indicated the mood interview for Resident #38's quarterly MDS assessment dated 9/4/19 should have been completed during the absence of the facility's Social Worker. She expected all MDS assessments to be complete and accurate.	F 642	RN MDS Coordinator will review to ensure that the assessment is complete prior to transmitting to the national data base. Unable to correct Resident #38 Quarterly assessment dated ARD 9/4/19 as the PHQ-9 was not completed. Significant correction of prior Quarterly scheduled with ARD of 11/5/19. District Director of Care Management and Area MDS RN Coordinator will review current residents with OBRA Admission, Annual, SCSA and Quarterly assessments completed and transmitted per Assessment History Report from 9/1/19 to 10/27/19 for accuracy of coding PHQ-9 or staff mood interview as appropriate. Assessments with errors identified will be corrected as appropriate by the MDS Coordinator. Audit will be completed by 11/8/2019. The District Director of Care Management is responsible for oversight and monitoring of 5 sample resident's weekly times four weeks and then 5 residents monthly for 2 months to review mood interview coding. Results of the monitoring will be taken to QAPI	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 658	F 658 D	11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 658	Continued From page 8 facility failed to follow physician orders resulting in missed medication doses for 1 of 6 residents reviewed for unnecessary medication (Resident #11). Findings included: Resident #11 was admitted to the facility7/11/19 with diagnoses that included diabetes mellitus, respiratory disease and hypertension. Resident #11's admission Minimum Data Set (MDS) assessment dated 7/18/19, an admission assessment revealed he was assessed to be cognitively intact. He was assessed to have shortness of breath with exertion and when lying down. Resident #11 received oxygen while in the facility. A physician's progress note dated 8/19/19 revealed a plan to change to add two medications to Resident #11's medication regimen. Resident #11 was seen for occasional cough. The note indicated Resident #11 has a non-hacking, productive cough. Long-acting insulin was added to his regimen due to use of prednisone. Review of Resident #11's Physician orders dated 8/19/19 revealed an order for Tessalon Perls 100 milligrams (mg) 1 capsule by mouth every 8 hours as needed and Lantus Solostar Solution 100 units/milliliter 6 units injected subcutaneously every morning. A review of Resident #11's August Medication Administration Record (MAR) an order date of 8/22/19 for the medications. There was no order for these medications on 8/19/19, 8/20/19 or 8/21/19. Lantus was given for the first time on	F 658	Services Provided Meet Professional Standards. -Resident #11, a prescriber's written medication was failed to be transcribed in a timely manner Medical Director was informed by the DNS on 10/03/19. -All charts were audited for new orders 10/7/2019 and repeated 10/28/19 to ensure the Medical Director was informed of missed doses by DNS/ Unit Manager upon each review and no variances were identified. -Medical director, reminded to please leave new orders flagged in charts; placed in rolling basket provided or to hand orders directly to nurses for transcription. -Nurses were provided education regarding expectations of transcribing new orders, and being alert for new possible orders when Physicians are in the facility completed by 11/8/19, DNS/Designee. -Night shift nurses to review all charts daily to ensure no orders are missed. -Audits of new orders to be reviewed during Daily Morning Clinical meetings by DNS/Designee. -The DNS/Designee will audit each new order for transcription (5) times a week for 4 weeks, then weekly times 1 month and every 2 weeks times one month to ensure that orders will be transcribed in a timely manner. The findings will be reviewed in QAPI times 3 months. The DON and Unit Manager are responsible for implementing the Plan of Corrections by 11/8/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 658	Continued From page 9 8/23/19. An interview was conducted with Resident #11 on 10/1/19 at 10:23 AM who stated he did not have any complaints about his care. He denied any concerns about his medications. Resident #11 indicated he did not recall the doctor's visit or the addition of medications on 8/19/19. An interview was conducted on 10/4/19 at 9:30 AM with the Director of Nursing (DON) who reported Resident #11's physician orders dated 8/19/19 were overlooked and she placed the orders when she discovered them on 8/22/19. The DON advised the provider did not flag the chart when the orders were added which led to the oversight. She reported the facility does not have a system for checking the charts for new orders daily.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, physician, and staff interviews the facility failed to obtain laboratory studies as ordered for 1 of 20 residents (Resident #31) and failed to obtain daily weights as ordered for 1 of 20	F 684	F 684 D Quality of Life Resident #12 did not suffer any ill effects to this incident.	11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 684	Continued From page 10 residents (Resident #12) reviewed for quality of care. Findings included: 1.Resident #31 was admitted to the facility on 6/21/19 with diagnoses including dementia, retention of urine, chronic atrial fibrillation (a heart rhythm disorder) and hypertension (high blood pressure). Review of Resident #31's most recent quarterly Minimum Data Set (MDS) assessment dated 8/21/19 indicated he was severely impaired for daily decision making. Review of a Physician's order for Resident #31 dated 9/16/19 indicated he was to have a complete blood count, a comprehensive metabolic panel and a prealbumin level drawn on 9/18/19. A Physician's order dated 9/30/19 indicated a request to fax Resident #31's laboratory study results from 9/18/19 to his physician. Review of Resident #31's medical record on 10/2/19 revealed no laboratory study results from 9/18/19 present in his record. Review of a nursing progress note dated 10/2/19 at 6:03 PM indicated Resident #31's physician had been notified that the laboratory studies ordered for 9/18/19 had not been drawn. It further indicated the physician explained these were routine laboratory studies and had given a new order for the laboratory studies to be drawn on 10/3/19.	F 684	-The Physician was informed by the Unit Coordinator on 10/2/2019 of the omissions of weights - An audit of current resident's charts to ensure all daily weight orders are properly obtained and documented in the medical records was completed the DNS and/ or Unit Coordinator by 11/8/2019. -The current Licensed Nursing staff will be educated regarding daily weight management guidelines by DNS and or Unit Coordinator by 11/8/2019. New employees will be in-serviced as part of orientation. - The DNS/Unit Coordinator or Designee will audit 5 times a weeks for 4 weeks, then weekly times 1 month, and then every 2 weeks times 1 month for weight completion documentation in the medical records, and proper follow through with MD notification on weight loss or gain per parameters. The findings will be reviewed in QAPI times 3 months. -The DNS and Unit Manager are responsible for implementing the Plan of Corrections by 11/8/2019. F684 D Quality of Life Resident #31 did not suffer any ill effects related to this incident The Physician was notified on 10/2/2019 by the Unit Coordinator of the laboratory omission, the lab was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 684	Continued From page 11 On 10/3/19 at 9:31 AM during an interview the facility Director of Nursing (DON) indicated the nurse placing the order for laboratory studies into the computer system was also to have placed a paper requisition for the studies into the laboratory book so laboratory personnel would know to draw the studies. She further indicated the nurse responsible for the order had been trained and should have done this. She stated this had not been done and Resident #31 did not get his laboratory studies drawn on 9/18/19 as ordered by his physician. On 10/3/19 at 11:30 AM an interview with Nurse #1 indicated he placed the order for Resident #31's laboratory studies on 9/18/19 into the computer system. He further indicated he should also have placed a paper laboratory requisition in to the facility's laboratory book for laboratory staff at that time but had not done so. He stated this caused Resident #31 to miss his laboratory studies on 9/18/19. He further indicated he was new to the facility and was used to night shift staff doing this. In a telephone interview on 10/10/19 at 2:06 PM Resident #31's physician indicated the facility did not have a policy on routine laboratory studies, so he liked to keep up with them himself. He further indicated he ordered Resident #31's laboratory studies for 9/18/19 to get a general picture of Resident #31's overall health status. 2. Resident #12 was admitted to the facility on 4/4/2019 with the diagnoses which included unspecified heart failure and chronic kidney disease stage three. A quarterly Minimum Data Set (MDS) dated	F 684	10/3/2019 and Physician made aware of results. -An audit of current resident's charts was completed to ensure all Laboratory orders were properly transcribed and that all laboratory requisitions are completed. Completed by Unit Coordinator on 10/07/19. - The current licensed nursing staff will be educated regarding laboratory management, laboratory requisition, and laboratory ordering completion by DNS or Unit Coordinator by 11/8/19. New employees will be in-serviced as part of orientation. -The DNS and/or Unit coordinator will audit 5 times a week for 4 weeks, then weekly times 1 month, and then every 2 weeks times 1 month for accuracy of proper laboratory order transcription with laboratory requisition completion and laboratory results received with MD notification of results. The findings will be reviewed in QAPI times 3 months. The DNS and Unit Coordinator are responsible implementing the plan of correction by 11/08/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 684	Continued From page 12	F 684		

7/19/2019 revealed Resident #12 was cognitively impaired and required extensive assistance with all activities of daily living (ADL) except for eating which the resident required set up assistance only.

A care plan dated 4/5/2019 and revised on 9/24/2019 revealed a plan which focused on Resident #12's coronary artery disease related to congestive heart disease with the interventions to administer all cardiac medications as ordered.

A physician orders dated 7/14/2019 revealed to weight Resident #12 daily indefinitely and to administer Lasix 40 mg twice a day.

The weight and vital sign summary for August 2019 and September 2019 revealed no weights were documented for the days of 8/4/2019, 8/6/2019, 8/10/2019, 8/17/2019, 8/19/2019, 8/22/2019, 8/24/2019, 8/29/2019, 9/1/2019, 9/3/2019 through 9/7/2019, 9/26/2019, 9/27/2019, and 9/30/2019.

During an interview on 10/2/2019 at 9:30 am with a Restorative Aide (RA), she revealed obtaining the resident weight was one of her RA responsibilities, but sometimes she was assigned to work as a Nursing Assistant (NA) on the unit. The RA also stated when she was assigned to work on the unit obtaining Resident #12's weight was assigned to whomever was working with the resident on that day.

An interview with a Unit Manager (UM) on 10/2/2019 at 10:30 am revealed the weights were the responsibility of the Restorative Aide (RA). When the RA worked on the unit as a Nursing Assistant (NA) it was the responsibility of the NA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 684	Continued From page 13 assigned to the resident that day to obtain the weights and document the results in the computer under the weights and vital signs section. On 10/3/2019 at 9:30 am during an interview with the Director of Nursing (DON), she stated a weekly weight list was reviewed by the Unit Manager and if the manager was aware of a missed weight, it would be obtained the next day. The DON also stated the nurses should have caught that Resident #12 had missing weights. The Administrator stated on 10/3/2019 at 11:00 am during an interview, if there was a physician order for daily weights, the weights should have been gotten as ordered. On 10/11/2019 at 8:55 am during an interview with Resident #12's Primary Care Physician (PCP), he revealed no weight parameters was added to the order because the weights were assessed on every visit to look for trends. The PCP further stated the Emergency Department recommendation to increase Resident #12's Lasix to 80 mg was not reviewed by him, and the physician that reviewed the recommendation was not familiar with the resident's care. The PCP further stated the resident's daily weights were discontinued because Resident #12 was made comfort care.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 686	Continued From page 14 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide wound care treatments as ordered by the physician for 1 of 1 resident (Resident #44) reviewed for pressure ulcers. Resident #44 was admitted to the facility on 8/13/2019 with diagnoses which included pressure ulcer of the sacral region (stage four). An Admission Minimum Data Set dated 8/20/2019 revealed Resident #44 had a stage four pressure ulcer and was cognitively impaired. The care plan dated 8/13/2019 focused on a plan for Resident #44 that specified the resident had a stage four pressure ulcer to the sacrum with interventions to administer treatments as ordered. Physician orders dated 8/13/2019 revealed to cleanse sacral stage four pressure ulcer with wound cleanse, pack with quarter strength antimicrobial cleanser moistened gauze, secure with a clean, dry dressing daily until healed. Treatment Administration Record (TAR) for August 2019 and September 2019 revealed the treatment for the sacral pressure ulcer had not	F 686	F686 D- Treatment/SVCS to prevent/ heal pressure ulcers - Resident #44 did not suffer any ill effects related to this incident. MD notified on 10/04/19 by DNS of the omissions. -An audit of the MD orders was completed to ensure treatment orders for current residents with wounds are in place. An audit of TAR's was completed to ensure all orders on the TAR's are signed off by the Licensed Nurses were completed for the month of October by DNS, Unit Coordinator or Designee by 11/08/19. Any variances were discussed with the attending physician. -Education to current licensed Nursing staff regarding signing of TAR and properly completing all assigned nursing duties per MD orders by DNS, Unit Coordinator or Designee by 11/08/19. New Employees will be in-serviced as part of orientation. -DNS, Unit Coordinator or Designee will audit for accuracy the TAR's, 5 times a week for 4 weeks, then weekly times 1 month, and then every 2 weeks times 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 686	Continued From page 15 been initialed for 8/26/2019, 8/29/2019, 9/21/2019, 9/22/2019, 9/28/2019 and 9/29/2019. A weekly pressure ulcer record dated 9/17/2019 revealed Resident #44's sacral wound bed was red in color with a moderate amount of bloody drainage, wound edges intact, odor was present, and peri wound (tissue surrounding the wound) was intact. A weekly pressure ulcer record dated 9/23/2019 indicated the stage four pressure ulcer was slightly larger in size, wound bed had 100 percent granulation tissue, a larger amount of serosanguinous drainage (yellow or clear drainage mixed with blood), odor and undermining noted. An interview with Nursing Aide # 1 (NA) on 10/4/2019 at 9:55 am revealed Resident # 44's appetite was good. The NA also stated the resident received and drank her supplements on a daily basis. Attempts to contact Nurse #3, Nurse #4, and Nurse #5 were made multiple times by telephone unsuccessfully on 10/3/2019 and 10/4/2019. Resident # 33's wound care had been assigned to these nurses on the days that wound care completion had not been documented on the TAR. On 10/3/2019 at 8:42 am during an interview with the Treatment Nurse, it was revealed she started in this role at the beginning of September 2019. The Treatment Nurse also stated she did not administer any wound care treatments until after she had been employed at the facility for two weeks.	F 686	month. The findings will be reviewed in QAPI times 3 months. The DNS, Unit Coordinator or Designee is responsible for implementing the plan of correction by 11/08/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 686	Continued From page 16 An interview on 10/3/2019 at 12:08 pm with the Unit Manager (UM) revealed he could not say if the treatments had been completed. The UM also stated he had not received any concerns about treatments not been completed. UM further stated it was his responsibility to make sure all assignments were completed. An interview with the Director of Nursing (DON) on 10/4/2019 at 9:00 am revealed the facility was without a treatment nurse for about three weeks and the nurses were responsible for doing the treatments. The DON also stated the nurses were made aware of the need to complete their own treatments. The DON further stated the Unit Manager would check to make sure the nurses were completing their assignments. During an interview with the Administrator on 10/4/2019 at 11:30 am, it was revealed the nurses should have completed the treatments for their assigned residents and initialed that the treatments had been completed.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 758	Continued From page 17 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, physician and staff interviews and record reviews, the facility failed to	F 758	F 758 Free from UNNEC Psychotropic MEDS/PRN use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 758	Continued From page 18 either limit prn (as needed) psychotropic drug use to 14 days or have a prescriber document a rationale in the resident's medical record for extension of use beyond 14 days for 1 of 1 resident (Resident # 33) reviewed for unnecessary medications. Findings included: Resident # 33 was admitted to the facility on 6/18/2019 with diagnoses which included major depressive disorder, and Alzheimer's disease. Resident's # 33's Minimum Data Set (MDS) dated 8/23/2019 indicated Resident # 33 had no mood or behavior symptoms. The resident required set up assistance with all activities of daily living. The resident received no anti-anxiety medication during the seven days look back period for the assessment. Review of physician's order dated 6/18/2019 revealed Lorazepam 1 milligram (mg) tablet by mouth every 12 hours as need for anxiety with no stop date indicated. Review of pharmacy consultation report dated 9/17/2019 addressed to Resident #33's Primary Care Physician (PCP) revealed a repeated recommendation from 7/16/2019 which stated Resident #33 had a PRN order for Lorazepam which had been in place for greater than 14 days without a stop date. Please discontinue PRN lorazepam, provide a rationale for continued use, or provide a duration of therapy. An interview with a Pharmacy Consultant on 10/1/2019 at 1:30 pm revealed a pharmacy recommendation was sent to Resident #12's	F 758	- The resident #33 did not suffer any ill effects related to this incident. This medication was discontinued on 10/03/19 by the Unit Coordinator via Physician orders. -An audit of current resident's charts was completed to ensure that PRN Psychotropic medications have a stop date or a rationale was in place in the medical record for extension of the use beyond 14 days by the DNS or Unit Manager on 10/4/19. -Education to the current licensed nurses and Physicians regarding psychotropic medication ordering with parameters for reevaluation, and if further use is necessary will be completed by the DNS, Unit Coordinator or Designee by 11/8/19. New employees will be educated as part of orientation. -DNS, Unit Coordinator or Designee will audit 5 times a weeks for 4 weeks, then weekly times 1 month and every 2 weeks times one month to ensure that PRN Psychotropic medication orders are properly written, by 11/08/19. The findings will be reviewed in QAPI times 3 months. -The DNS and Unit Coordinator are responsible for the implementing the Plan of Correction by 11/08/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 758	Continued From page 19	F 758		

Primary Care Physician on 7/16/2019 and 9/17/2019 concerning a Lorazepam order over 14 days.

Review of Medication Administer Record (MAR) for July, August, September 2019 revealed Lorazepam 1 mg had been available to Resident # 33 and administered only on 9/25/2019 for anxiety.

An interview with the Unit Manager (UM) on 10/1/2019 at 4:30 pm revealed pharmacy recommendations were printed off the computer by the Director of Nursing once a month and placed in the Physician's mailbox for evaluation. The UM also stated once a psychotropic medication was discontinued, he would personally remove the medication from the medication cart and send it back to the pharmacy.

An observation on 10/3/2019 at 1:30 pm with Nurse #5 revealed Resident #33 had a package of Lorazepam 1 mg tablets in the narcotic box on the 300 hall medication cart.

On 10/4/2019 at 4:00 pm during an interview with Resident #33's PCP, it was revealed that he was familiar with the 14- day time limit and the PRN psychotropic process. The PCP also stated after 14 days the psychotropic medication usually drops off the medication orders if not renewed. The PCP further stated he could not remember if he had received the first pharmacy recommendation because he received so many. The PCP indicated the DON would print off the recommendations at the end of every month and place the recommendations that needed to be addressed in his mail box. The PCP further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 758	Continued From page 20 stated, he usually wrote an order or discontinued the medication and hand the paperwork to a nurse. The July 2019, August 2019, and September 2019 MARs revealed the Lorazepam orders as current and there was no physician order in the medical record to discontinue the medication.	F 758		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility ' s quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification survey dated 9/27/2018 in order to achieve and sustain compliance. This was for a recited deficiency on a recertification survey dated 10/11/2019. The deficiency was in the area of resident assessment. The continued failure during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective quality assurance program. Findings Included: This tag is cross-reference to: CFR 483.20 (F641) Based on record review and staff interviews the facility failed to accurately	F 867	F 867 The facility failed to accurately code MDS for the recertification survey dated 9/27/18 and this was recited deficiency with the recertification survey 10/11/19. Corrective action was accomplished for the alleged deficient practice by the Administrator holding an Ad Hoc QAPI meeting on 10/31/19 to discuss the outcomes of the annual survey and repeat citations of F641. QAPI education was provided for the Administrator and Interdisciplinary Team by the District Director of Clinical Services on 10/31/19. The education included the Sava QAPI program and the expectations associated with the program. The	11/8/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 867	Continued From page 21 code the Minimum Data Set (MDS) to reflect the use of a wander alarm for 1 of 1 resident reviewed for restraints (Resident # 31). During the facility ' s 09/27/18 recertification survey the facility was cited for F-641 for failure to accurately code on a quarterly assessment the presence of a wander alarm and failed to accurately code tube feeding for 2 of 16 resident Minimum Data Set (MDS) assessments reviewed (Residents #31 and Resident #8). During an interview with the Administrator on 10/04/2019 at 11:07 am, the Administrator stated after discussing the correction plans and how the goals would be achieved, she believed that human error slipped in to make the QA plans unsuccessful. The administrator also stated they would have to go back and make sure all resident ' s assessments were code correctly and increase the MDS record reviews. She further stated a new MDS staff member had been hired to assist with residents ' assessments.	F 867	program enables the identification of opportunities for improvement, prioritization of those opportunities, root cause analysis, performance improvement plans and routine evaluation of the plan, do, study, act philosophy to ensure sustainability The MDSC's that were responsible for the findings on the 10/11/19 recertification survey are no longer employed at the facility. Education was provided by the District Director of care management to the current MDS RN coordinator, the Activity Director, the Administrator, the Director of Nursing, the Director of Rehab, and the Director of social services in relation to MDS accuracy. In-service was completed on 10/28/19. Modifications for the cited areas on 10/11/19 survey have been completed and transmitted by the MDS coordinator on the identified MDS referenced in F 641 plan of correction . The Administrator will conduct a weekly QAPI meeting to review the monitoring of the five sample residents that the District Director of care management is conducting for MDS accuracy weekly for four weeks. The Administrator will conduct monthly QAPI meeting to review the monitoring of the five sample residents that the District Director of care management is conducting for accuracy for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	**1306 SOUTH KING STREET WINDSOR, NC 27983**

(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 867	Continued From page 22	F 867	The District Director of care management and or the District director of Clinical services will then do random audits for MDS accuracy for the next 9 months. The Administrator and Director of Nursing will analyze the data obtained from the random audits and report any patterns and/or trends to the QAPI Committee monthly. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance. The administrator is responsible for implementing the Plan of Correction by 11/8/19.	