DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	LE CONSTRUCTION	( - )	TE SURVEY MPLETED
		345149	B. WING			C 8/11/2016
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & RETIREME	NT		4911 BRIAN CENTER LANE		
				WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
F 334	No citations as a resi investigation. 2Q8M 483.25(n) INFLUENZ	-	F 33	4		9/7/16
	that ensure that (i) Before offering the each resident, or the representative receive benefits and potential immunization; (ii) Each resident is or immunization Octobe annually, unless the in contraindicated or the immunized during this (iii) The resident or th representative has the immunization; and (iv) The resident's me	es education regarding the side effects of the ffered an influenza r 1 through March 31 mmunization is medically e resident has already been s time period; e resident's legal e opportunity to refuse				
	<ul> <li>(A) That the residen representative was prithe benefits and poter immunization; and</li> <li>(B) That the residen influenza immunization influenza immunization contraindications or resident that ensure that</li></ul>	rovided education regarding ntial side effects of influenza t either received the on or did not receive the on due to medical efusal.				
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE

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.

09/02/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 09/12/2016 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345149	B. WING				C 11/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & RETIREME	NT			911 BRIAN CENTER LANE VINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	the benefits and pote immunization; (ii) Each resident is o immunization, unless medically contraindica already been immuniz (iii) The resident or th representative has th immunization; and (iv) The resident's me documentation that in following: (A) That the residen representative was put the benefits and pote pneumococcal immunithe pneumococcal immunithe pneumococ	ntial side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; le resident's legal e opportunity to refuse edical record includes adicated, at a minimum, the t or resident's legal rovided education regarding ntial side effects of nization; and t either received the nization or did not receive munization due to medical fusal. based on an assessment nmendation, a second nization may be given after 5 st pneumococcal medically contraindicated or sident's legal representative	F	334			
	by: Based on record revi facility failed to docum medical record that e benefit and potential vaccine and the pneu	is not met as evidenced iews and staff interviews, the nent in the resident 's ducation regarding the side effects of the influenza imococcal vaccine were ent or legal representative for			1.Interdisciplinary Team Members and clinical staff were educated on the poli and procedure related to resident education regarding the benefit and potential side effects of the influenza vaccine and the pneumococcal vaccin	су	

Event ID: 2Q8M11

Facility ID: 952994

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	IPLETED
						С
		345149	B. WING		0	8/11/2016
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
				4911 BRIAN CENTER LANE		
BRIANCI	R HEALTH & RETIREME			WINSTON-SALEM, NC 27106		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 334	Continued From page	a 2	F 33	34		
1 001		wed for influenza and	F 50	54		
		ation (Resident #57, #68,		2.All residents have the po	tential to be	
	#72, #82 and #83).	$\frac{1}{1000}$		affected by this alleged de		
	Findings included:			An audit of current resider		
	-	admitted to the facility on		records was conducted or	8/11/2016.	
	4/1/2016 with multiple	e diagnoses that including		Residents that had refuse	d the flu and/or	
	Respiratory Failure.			pneumococcal vaccine we	ere re-educated	
	A review of Resident	#57 's medical record		at that time related to pote	ntial side	
	revealed a consent d			effects and benefits of the		
		ienza immunization and		pneumococcal vaccine. Fo	-	
	-	nization were signed by		education, no resident was		
	Resident #57. Reside			the flu and/or pneumococo		
	vaccines. There was			Resident #57 was educate		
		lical record regarding the I side effects of the influenza		and potential side effects of vaccine and pneumonia in		
		imonia immunization.		documentation was placed		
		on 8/10/2016 at 10 AM with		Resident #68 was educate		
	•	ng (DON) revealed residents		and potential side effects		
	or legal representativ			vaccine and pneumonia in		
		regarding the influenza and		documentation was placed		
	the pneumonia immu	inizations during the		Resident #72 was educate	ed on benefits	
	admission process. C	Continued interview with the		and potential side effects of	of the influenza	
	DON revealed she co			vaccine and pneumonia in		
		s education regarding the		documentation was placed		
		I side effects of the influenza		Resident #82 was educate		
		umonia immunizations in		and potential side effects of		
	Resident #57 's med			vaccine and pneumonia in		
		rdinator who admitted		documentation was placed		
	facility and was unab	longer employed at the		new flu and pneumococca consent form was signed l		
		on 8/11/2016 at 1:45PM with		and was placed in the med		
		ealed that she nor the DON		Resident #83 was educate		
	where here during the			and potential side effects of		
		dministrator indicated that		vaccine and pneumonia in		
	after this survey she			documentation was placed		
		nd rearranged some of this				
	concerns in this facili	ty. Administrator indicated				
		would be that admissions				
	coordinator would pro	ovide the educational				

Facility ID: 952994

If continuation sheet Page 3 of 13

					OMB NO. 093	
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
			A. BUILDING	3	с	
		345149	B. WING		08/11/20	16
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		10
				4911 BRIAN CENTER LANE		
BRIAN CI	R HEALTH & RETIREME	EN I		WINSTON-SALEM, NC 27106		
(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	TION SHOULD BE COME THE APPROPRIATE	(X5) PLETIO DATE
F 334	Continued From page	e 3	F 33	34		
1 001		and/or legal representatives.	1.00		ee will educate	
		as admitted to the facility on		3.The DON and/or design the Licensed staff on com		
		iple diagnoses that including		documentation in the resid	-	
	Anemia and Seizure			record regarding the bene		
	A review of Resident	#68 's medical record		the flu and/or pneumococ		
	revealed a consent d	ated 4/12/2016 for		DON and/or designee will		
	administration of influ	enza immunization and		pneumococcal immunizat		
	pneumococcal immu	nization were signed by		forms upon admission and	d weekly x 4	
		l representative. Resident		weeks. Any opportunities		
	#68 ' s legal represer			corrected by the DON or o	lesignee at that	
	vaccines. There was			time.		
		lical record regarding the				
		I side effects of the influenza		4. The results of these au		
		umonia immunization.		reported in the Quality As		
		on 8/10/2016 at 10 AM with		Performance Improvemen		
	or legal representativ	ng (DON) revealed residents		DON for 3 months, then q quarters. The committee v		
		regarding the influenza and		make further recommenda		
	the pneumonia immu			indicated.		
		Continued interview with the				
	DON revealed she co					
		s education regarding the				
		I side effects of the influenza				
		umonia immunizations in				
	Resident #68 's med	lical records.				
		rdinator who admitted				
		longer employed at the				
	facility and was unab					
	•	on 8/11/2016 at 1:45PM with				
		ealed that she nor the DON				
	where here during the	e admission of the 5				
	after this survey she					
		nd rearranged some of this				
	-	ty. Administrator indicated				
		would be that admissions				
	coordinator would pro					
	-	and/or legal representatives.				
		as admitted to the facility on	1			

Facility ID: 952994

If continuation sheet Page 4 of 13

		MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		COM	
						С
		345149	B. WING		08/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
				4911 BRIAN CENTER LANE		
	R HEALTH & RETIREME			WINSTON-SALEM, NC 27106		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 334	Continued From page	o.4	Г 22	4		
			F 334	*		
		ble diagnoses that including				
	Respiration Failure.	#72 ' s medical record				
	revealed a consent d					
		ienza immunization and				
		nization were signed by				
	-	ent #72 received both				
	vaccines on that day.					
	-	sident #72 ' s medical record				
		s and potential side effects				
		ine and the pneumonia				
	immunization.					
		on 8/10/2016 at 10 AM with				
		ng (DON) revealed residents				
	or legal representativ					
		regarding the influenza and				
	the pneumonia immu					
	· ·	Continued interview with the				
	DON revealed she co					
		s education regarding the				
		I side effects of the influenza				
	-	umonia immunizations in				
	Resident #72 ' s med					
	The Admissions Cool	rdinator who admitted				
	Resident #72 was no	longer employed at the				
	facility and was unab	le to be interviewed.				
	During an interview of	on 8/11/2016 at 1:45PM with				
	the Administrator rev	ealed that she nor the DON				
	where here during the					
		dministrator indicated that				
	after this survey she					
		nd rearranged some of this				
		ty. Administrator indicated				
	-	would be that admissions				
	coordinator would pro					
		and/or legal representatives.				
	4. Resident #82 wa	as admitted to the facility on				
		ble diagnoses that including				

Facility ID: 952994

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345149	B. WING				C 11/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CT	R HEALTH & RETIREME	NT			911 BRIAN CENTER LANE VINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	A review of Resident a a consent not dated for influenza immunization immunization were sig Resident #82 refused no documentation in H record regarding the H effects of the influenz pneumonia immunization or legal representative educational material in the pneumonia immuni admission process. C DON revealed she con documentation of this benefits and potential vaccine and the pneu Resident #82 's medi The Admissions Coor Resident #82 was no facility and was unabl During an interview of the Administrator reverse where here during the sampled residents. An after this survey she w department heads an concerns in this facilit that her expectation w coordinator would pro- material to residents a 5. Resident #83 was	<ul> <li>#82 medical record revealed or administration of on and pneumococcal gned by Resident #82. both vaccines. There was Resident #82 's medical benefits and potential side a vaccine and the tion.</li> <li>n 8/10/2016 at 10 AM with g (DON) revealed residents es were provided regarding the influenza and nizations during the continued interview with the buld not locate any education regarding the influenza monia immunizations in ical records</li> <li>redinator who admitted longer employed at the e to be interviewed.</li> <li>n 8/11/2016 at 1:45PM with ealed that she nor the DON e admission of the 5 dministrator indicated that would meet with all d rearranged some of this y. Administrator indicated would be that admissions ovide the educational and/or legal representatives. as admitted to the facility on e diagnoses that including</li> </ul>	F	334			

Facility ID: 952994

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			
		345149	B. WING		C 08/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
	R HEALTH & RETIREM			4911 BRIAN CENTER LANE		
BRIANCI	R HEALTH & RETIREM			WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI HE APPROPRIATE DATE	
F 334	Continued From pag	e 6	F 33	4		
		nt #83 ' s medical record	1.00			
	revealed a consent d					
	administration of influ	uenza immunization and				
	-	nization were signed by				
		ent #83 received both				
	vaccines on that day	. There was no sident #83 's medical record				
		s and potential side effects				
		ine and the pneumonia				
	immunization.					
	During an interview of	on 8/10/2016 at 10 AM with				
		ng (DON) revealed residents				
	or legal representativ					
		regarding the influenza and				
	the pneumonia immu	Continued interview with the				
	DON revealed she co					
		s education regarding the				
	benefits and potentia	I side effects of the influenza				
	· ·	umonia immunizations in				
	Resident #83 ' s med					
		rdinator who admitted				
	facility and was unab	longer employed at the				
	•	on 8/11/2016 at 1:45PM with				
	-	ealed that she nor the DON				
	where here during th	e admission of the 5				
		dministrator indicated that				
	after this survey she					
		nd rearranged some of this				
		ity. Administrator indicated would be that admissions				
		ovide the educational				
		and/or legal representatives.				
F 431	483.60(b), (d), (e) DF		F 43	1	9/7/16	
SS=E	LABEL/STORE DRU	IGS & BIOLOGICALS				
			1		1	

Facility ID: 952994

If continuation sheet Page 7 of 13

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/12/2016 // APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l í í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345149	B. WING				C 11/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & RETIREME	NT	4911 BRIAN CENTER LANE				
DIVIANO				WINSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 431	a licensed pharmacisi of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. In accordance with St facility must store all o locked compartments controls, and permit of have access to the ke The facility must prov permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 an abuse, except when t package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on record revi facility failed to follow provide for an accurate	t who establishes a system and disposition of all fficient detail to enable an n; and determines that drug nd that an account of all aintained and periodically used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when ate and Federal laws, the drugs and biologicals in under proper temperature inly authorized personnel to eys.	F	431	1.All licensed Nurses were re-educate on the policy and procedure for accurar reconciliation and verification of all controlled substances.	-	

Event ID: 2Q8M11

Facility ID: 952994

If continuation sheet Page 8 of 13

	S FUR IVIEDICARE &	MEDICAID SERVICES				<u>IO. 0938-03</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345149	B. WING		C 08/11/2016	
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0/11/2010
				4911 BRIAN CENTER LANE		
3RIAN CT	R HEALTH & RETIREME	INT		WINSTON-SALEM, NC 27106		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 431	Continued From page	- 8	F 43	1		
	carts (Front I medication cart.) Findings included: The facility 's proceed dated 9/2011 stated substances are invent required by State and Reconcile the declinition beginning and end of performed by a physic medications by two p authorized to administ The Pharmacy Consta 8/11/16 at 10:08 AM. she reviewed all the of report of recommend completing extra aud residents on Courace would look at the dec count book and comp not been any discrep the controlled substate are doing the counts. spots here and there she sees that a lot pla had reported it the Di some point. She state Monday. She could in any issues with the co on Monday but would Review of the Quality Pharmacist Summary through 4/30/16 revent	tion cart and back II ure for controlled drugs " to ensure that controlled toried and administrated as d Federal regulations. " " ng inventory record at the each shift. Reconciliation is cal count of the remaining ersons who are legally ster medications. " ultant was interviewed on She stated once a month charts and submitted a ation. She had also been its since the last survey for lin. The pharmacy technician dining controlled substances bare it to the cart. There has ancies. She also reviewed nce book to see if the nurses They have found some of missing signatures and aces. She was sure that she rector of Nursing (DON) at ed she was there on ot remember if there were ontrolled substance counts d fax the reports. Improvement Consultant y period covered from 4/1/16 aled controlled substance	F 43	<ul> <li>2.All residents have the potential affected by this alleged deficient An audit of all Controlled Drugs-C Records was conducted on 8/11/ to the findings and potential confexisting form, a new Controlled Drugs-Count Record was implen</li> <li>3. The DON and/or designee will re-educate all Licensed Nurses of policy and procedure for accurate reconciliation and verification of a controlled substance sheets. All Staff will be oriented upon hire in Orientation on the policy and profor accurate reconciliation and verification and verification and verification of all controlled substances. The and/or designee will audit the Co Drugs-Count Records daily x 4 we then 3 times per week x 4 weeks weekly x 4 weeks. Opportunities addressed/ corrected by the DOI designee with appropriate license Pharmacy Consultant visited fact 8/31/16 and conducted audit of a Controlled Drugs-Count Records found zero errors. Pharmacy Conwill make every other week visits facility x 8 weeks to ensure comp with the Controlled Drugs-Count</li> </ul>	practice. Count (16. Due fusion of mented. on the e all Licensed cedure erification DON introlled veeks, and then will be N and/or ed staff. ility on all and moultant to the pliance Records.	
	the staff member was nurses signatures wh and on counting carts	0-40% complete. It stated s " not able to find the here they were reporting off s. I see shift count sheets in t was discussed with facility		reported in the Quality Assurance Performance Improvement meet DON for 3 months, then quarterly quarters. The committee will eva make further recommendations a	ing by the y x 3 luate and	

Facility ID: 952994

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345149	B. WING				C 11/2016
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CT	R HEALTH & RETIREME	NT			4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 431	Review of the Quality Pharmacist Summary through 6/30/16 reveat documentation was 1 controlled substance resolution was in prog The Controlled Substa dated 7/13/16 complet technician revealed th signatures every shift sheets. Review of the Quality Pharmacist Summary through 8/31/16 reveat documentation was 3 shift documentation was 3 shift documentation was pharmacist recomment conference with the D Quality Assurance Clii Review of the controll count sheets revealed and/or the total amout amount of sheets were shifts for Front I medit 5/10/16- all shifts missi signatures 5/12/16- 7:00 AM- 3:0 dual signatures 5/13/16 - 7:00 AM- 3:0 shifts missing count a 5/17/16 - All shifts missi	Improvement consultant period covered from 6/1/16 aled controlled substance 0-20% complete. Under documentation, it stated a gress. ance Documentation audit ted by the pharmacy here were 2 missing on the declining inventory Improvement consultant period covered from 8/1/16 aled controlled substance 0-40%. It stated that shift to vas spotty and to see ndations. On 8/4/16, an exit 0ON was conducted with the nician. ded substance inventory d that dual (2) signatures nt of containers and/or total re missing for the following cation cart. sing counts and dual 00 PM missing counts and 00 PM shift missing count 00 PM; 11:00 PM- 7:00 AM nd dual signatures sing counts and signatures 00 PM; 11:00 PM- 7:00 AM and signatures	F	431			

Facility ID: 952994

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 09/12/2016 RM APPROVED IO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345149	B. WING			0	C 8/11/2016	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CT	R HEALTH & RETIREME	NT			011 BRIAN CENTER LANE /INSTON-SALEM, NC 27106			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	Continued From page	e 10	F 4	.31				
	5/21/16- all shifts mis signatures							
	dual signatures	:00 AM missing count and 1:00 PM missing count and						
	dual signatures 5/24/16 - all shifts mis	-						
	signatures 6/6/16 - 6/10/16- all s signatures	hifts missing count and dual						
	signatures	ssing counts and dual						
	dual signatures 7/16/16- 11:00 PM- 7	shifts missing count and :00 AM missing dual						
		shifts missing count and dual						
	signatures 7/22/16- 7/25/16- all s signatures	shifts missing count and dual						
	0	00 PM missing count and						
		led substance inventory d that dual (2) signatures						
		Int of containers and/or total re missing for the following ination cart						
		shifts missing count and						
	signatures	hifts missing count and dual						
	signatures	ifts missing count and dual shifts missing count and dual						
	signatures 7/25/16- 7/29/16- all s	shifts missing count and dual						
	signatures 8/7/16- All shifts miss	ing count and dual						

Facility ID: 952994

If continuation sheet Page 11 of 13

DEPARTMENT OF HEALTH ANI CENTERS FOR MEDICARE & N				FC	ED: 09/12/2016 RM APPROVED NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
	345149	B. WING			C 08/11/2016
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZI		
		4	911 BRIAN CENTER LANE		
BRIAN CTR HEALTH & RETIREMEN		v	VINSTON-SALEM, NC 27106		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 431 Continued From page signatures	11	F 431			
AM. She stated they c shift. She stated they c that was coming on an medications were coun medication book would controlled substances discontinued medication the pharmacy usually shift. The controlled su until they went back to medications would als shift change. Nurse #1 was interview AM. He stated the medications where the controlled si was from 8/2/16 throug maybe it was not filled The Director of Nursin on 8/11/16 at 9:45 AM expectation was when they follow the policy a controlled medications to the oncoming nurse the completed sheet w Then they need to go controlled substance s time. Then document th have on the controlled The oncoming nurse n inventory sheet and co	ons would be sent back to on the 3:00 PM to 11:00 PM ubstances stayed in the cart of the pharmacy and those of be counted during the wed on 8/10/16 at 10:40 dications were counted the oncoming nurse and the d then sign the controlled sheets. He was not sure ubstances documentation gh 8/10/16. He stated that out for those days. g (DON) was interviewed . She stated her the nurse came on shift and procedure for counting s. The off going nurse would sheet before they count off to make sure the card and was removed if needed. through and count the sheets they have at that the amount of sheets they substance inventory sheet.				

Facility ID: 952994

If continuation sheet Page 12 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 09/12/2016 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345149	345149 B. WING				C 08/11/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CTR HEALTH & RETIREMENT				4911 BRIAN CENTER LANE				
				<u> </u>	INSTON-SALEM, NC 27106			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		OULD BE COMPLETION		
F 431	and compare to the control inventory sheet. The inventory sheet. The inventory sheets. She substance sheets. She nurses and they signed had been completed. another one that had A verbal in-service ab controlled substances 8/1/16 per the Association (ADON). The in-service inverse of the inve	cards in the narcotic drawer ontrolled substance nurse consultant had not with counting of the control ue did one on 8/9/16 with the ed verifying the in-service She stated there was also been completed. bout change of shift s counts was completed on ate Director of Nursing ce was dated 8/1/16. Nurse ed on 8/11/16 that they	F	431	DEFICIENCY)			
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:2Q8	M11	Faci	ility ID: 952994 If contin	uation shee	t Page 13 of 13	