DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	LE CONSTRUCTION		TE SURVEY
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING	i		
			5.14/11/0				С
		345343	B. WING			0	1/12/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			1700 WAYNE MEMORIAL DRIVE		
					GOLDSBORO, NC 27534		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
IAG					DEFICIENCY)		
F 580	Notify of Changes (In	jury/Decline/Room, etc.)	F	580	n		2/9/18
SS=D				500	0		2/3/10
55-D							
	§483.10(g)(14) Notific	cation of Changes.					
		ediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe	en there is-					
	(A) An accident involv	ing the resident which					
		as the potential for requiring					
	physician interventior						
		ge in the resident's physical,					
	mental, or psychosoc	•					
		n, mental, or psychosocial					
		reatening conditions or					
	clinical complications	, atment significantly (that is,					
	a need to discontinue						
		erse consequences, or to					
	commence a new for	-					
	(D) A decision to tran						
	resident from the faci	-					
	§483.15(c)(1)(ii).						
	(ii) When making noti	fication under paragraph (g)					
	(14)(i) of this section,	the facility must ensure that					
		on specified in §483.15(c)(2)					
		ded upon request to the					
	physician.						
		also promptly notify the					
		lent representative, if any,					
	when there is-	or roommate assignment					
	as specified in §483.1						
		ent rights under Federal or					
		ns as specified in paragraph					
	(e)(10) of this section						
		ecord and periodically					
		mailing and email) and					
	phone number of the						
	representative(s).						
	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	2F		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

02/05/2018

PRINTED: 02/21/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

		ID HUMAN SERVICES MEDICAID SERVICES			FORM): 02/21/201 1 APPROVE 0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		345343	B. WING			」 12/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO	1	700 WAYNE MEMORIAL DRIVE		
			0	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	Continued From page	e 1	F 580			
	that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on record rev interviews, the facility of the absence of urir in a newly inserted in approximately 6 hour Physician of a Regist recommendation for feeding which resulte 1 of 1 residents (Resi Findings included: 1a	an increase in the tube d in a delay of treatment for ident #303). ed Resident #303 was		Resident #303 was discharged o 8/31/2017 and has not returned to facility. 1a. The Director of Nursing or de will complete an audit of physicia and the facility's twenty four hour for the past thirty days to ensure and/or resident representative no for residents with significant char condition , to include absence of catheter bag . 1b. The Director of Nursing or dea will complete an audit of the previous months Registered Dietitian recommendations to ensure that	o the esignee in orders reports physician otification nge in urine in a signee ious	
	Hyperplasia (enlarge which is a gland locat history of Cerebral Va Review of the Admiss (MDS) dated 8/22/20 was moderately cogn the assistance of 2 po	uded Benign Prostatic ment of the prostate gland, ted below the bladder) and a ascular Accident (stroke). sion Minimum Data Set 17 indicated the resident itively impaired and required ersons with activities of daily rated the resident was bowel and bladder.		 attending physician was notified t and appropriate changes made to resident's diet were completed. 1b. The Director of Nursing or des will re-educate all licensed nurses facility process for pending /confit physician orders. Any licensed n does not receive the education w prior to working their next schedu Newly hired licensed nurses will r the education during new hire the 	o the signee s on the ming urse that ill receive led shift. eceive	

Facility ID: 922984

		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	TE SURVEY
						С
		345343	B. WING		(01/12/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	e 2	F 5	80		
		d 8/29/2017. The progress	10	1b. The facility clinical ma	nagers to	
		sident was seen by the		include Director of Nursing	-	
	physician. The progre	-		Development Coordinator	-	
		ade fever, oxygen saturation		Managers will be provided		
	was 87% on room air	, blood pressure was		regarding registered dietit	ian	
		lear, heart rate was regular,		recommendation to includ		
		o edema (swelling) was		physician notification and		
	•	ent responded to verbal		the recommendation by th	e facilitiy's	
		n's orders included to obtain		district clinical director.		
	• •	s for a CBC, CMP and		1a. The Director of Nursin		
		-analysis of urine) with ty (C&S-a test which may		will re-educate facility lice	•	
	grow and identify bac			staff regarding physician r significant change in resid		
	grow and identity bac	aena in unnej.		Any licensed nurse that de		
	Record review of the	nursing notes revealed		the education will receive		
		Irse #1 on 8/29/2017 at 9:18		their next scheduled shift.		
	PM which indicated F			licensed nurses will receiv	•	
	catheterized for a Uri	nary Analysis (UA-analysis		during new hire orientation	า.	
		and Sensitivity (C&S-a test		1a. The Director of Nursin	g or designee	
		identify bacteria in urine) per		will review the twenty fou	r hour report	
		The nursing note reported		and physician orders from		
		eterized at 6:00PM and the		to ensure that the physicia		
	•	e were: blood pressure		of significant changes in the		
		pirations 20, temperature		condition timely, daily for		
		ration was 84% to 89% with note revealed there was		weekly times four then mo	onthiy times	
		catheterization, there was no		three. 1b. The Facility's district of	linical director or	
	-	ation and the catheter was		designee will review the R		
		e indicated the resident did		Dietitian's monthly recom		
	-	s and family was at the		times 3 months to ensure		
	bedside.	•		recommendations were for		
				timely by the facility.	-	
		nursing notes revealed a		The physician notification		
	note documented by			report/physician order auc		
		as called to Resident #303's		Dietitian Recommendation		
		noted the resident was pale		will be reviewed by the fac		
		e note further indicated		team weekly times 4 week	•	
		ount of blood in the catheter ng. The resident's vital signs		times 3 months and all ne will be addressed and furt		
	and the catheter tubir	na The recident's vital signs		will be addressed and furt	har advartian	

Facility ID: 922984

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE COMP		
		345343	B. WING				_ 12/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
BRIAN CE	INTER 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 580	were documented in 1 93/56, pulse 104, terr 20 and his oxygen sa The note revealed the bedside and requeste the emergency depar documentation revea notified and the residu ambulance at 12:10 Å An interview was con 1/12/2017 at 8:58AM. remembered Resider when a resident is inco ordered, she used an obtain urine for the sp there was blood retur bag. Nurse #1 indicat collection bag or tubir indicated although sh the rest of the evenin reevaluate the cathet stated she probably of inform him of the lack of blood in the urinary recalled there was a l she just forgot to call An interview was cor on 1/12/2018 at 9:40/ did not recall Resider indicated he certainly the absence of urine an indwelling cathete would expect to be no insertion if there was collection bag.	the note as: blood pressure operature 98.6, respirations turation was 88% to 89%. The resident's family was at the ed the resident to be sent to tment for evaluation. The led the physician was ent left the facility by AM on 8/30/2017. The Nurse #1 reported she at #303. The nurse stated continent and a UA is in and out catheter to becimen. Nurse #1 recalled n in the tubing and collection ed there was no urine in the ng. Nurse #1 further e monitored the resident for g shift, she did not er for placement. Nurse #1 lid not call the physician and c of urine and the presence v collection bag because she ot going on that evening and	F	580	provided as needed.			

Facility ID: 922984

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345343	B. WING _				C 12/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			700 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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	DON stated the expert to be notified with the absence of urine whe catheter is placed. 1b Record review reveal admitted to the facility diagnoses which inclu- swallowing) with Gast tube through the abdo Cerebral Vascular Act Record review of Res orders dated 8/15/207 formula orders for cor- milliliters (mls) per ho per hour and before a ordered. Record review of Res Plan dated 8/15/2017 nutrition and hydration weights through the m Record review of Res revealed a weight on and a weight on 8/21/ Documentation revea obtained by the bed s Review of the 7-day A Set (MDS) dated 8/22 was moderately cogn the assistance of 2 pe living. The MDS indic tube feeds for all his r	2/2018 at 10:30AM. The ctation was for the Physician presence of blood and the man indwelling urinary ed Resident #303 was y on 8/15/2017 with uded Dysphagia (difficulty in trostomy Status (feeding ominal wall) and a history of cident (stroke). sident's Admission Physician 17 revealed tube feeding ntinual feedings of 50 ur, water flushes at 125 mls and after medications as sident #303's initial Care ' included a goal of adequate n as evidenced by stable text review. sident #303's weights 8/16/2017 of 134 pounds. led both weights were scale. Admission Minimum Data 2/2017 indicated the resident itively impaired and required ersons with activities of daily ated the resident received nutritional needs. The Care	F	580			
	Area Assessment (CA						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/21/2018 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345343	B. WING				C 12/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	INTER HEALTH AND REF	HABILITATION/GOLDSBORO			700 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 PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	and was totally depennutritional needs and feeds. Review of the clinical documentation from til (RD) dated 8/27/2017 Resident #303 was at underweight status. Tresident required increases and the required increases and the electron of the	adent on staff for his administration of tube progress notes revealed he Registered Dietician 7. The note indicated t a nutritional risk due to his the note indicated the eased nutrient needs and ease the formula feeds to nic record revealed a ed 8/27/2017 (entered into by the RD) to increase ula tube feeds to 55 mls an noted as pending v of the Medication d and the Treatment d revealed the formula tube used per the RD ducted with the RD on 4. The RD indicated she did 303. The RD reviewed the ndicated although the tube hospital upon admission It the resident needed more uased on what his weight dicated she sent the the nursing department via commendation in the es would see it was flagged	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345343	B. WING				C 12/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
BRIAN CE	INTER 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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	An interview was con Nursing (DON) on 1/ ⁷ DON indicated the re RD had to be confirm an email from the RD The DON stated she not see an email for t An interview was con Clinical Director on 1/ Cooperate Clinical Di had 48 or 72 hours to to the Physician for re Clinical Cooperate Di recommendation was 8/27/2017 at 8:30PM discharged to the hos 12:10AM. An interview was con Administrator (ADM) The ADM indicated th formula increase for F been reviewed in the day after it was enter ADM stated there wa order was not reviewed An interview was con 1/11/2018 at 7:14PM. did not recall Resider indicated when the R he expected the reco in his box located at t could address them a Physician stated if the recommendation to in due to weight loss an	ducted with the Director of 11/2018 at 11:15AM. The commendations from the ed and usually she received with the recommendations. looked in her email and did he recommendations. ducted with the Cooperate (11/2018 at 11:30AM. The rector indicated the facility oget the recommendations eview and completion. The rector stated the a put in the computer on and the resident was apital on 8/30/2017 at ducted with the on 1/11/2018 at 3:30PM. He order for the tube feeding Resident #303 should have daily clinical meeting the ed in the computer. The s no way to know why the ed and confirmed. ducted with the Physician on The Physician reported he at #303. The Physician D made recommendations, mmendations to be placed he nursing station so he as soon as possible. The	F	580			

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		C		
		345343	B. WING		01/12/2018		
NAME OF PI	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 580	Physician reported he	e was usually in the facility	F 580				
F 658 SS=D	think the increase in the resident would have a resident's weight in sup- Physician indicated he inform him of RD reco- computer system doe Physician stated the sup- changed to prevent do Services Provided Me	made any difference in the uch a short time. The e relied on the facility staff to commendations as the es not alert him. The system needed to be elays in residents' needs. eet Professional Standards	F 658		2/9/18		
	as outlined by the cor must- (i) Meet professional This REQUIREMENT	d or arranged by the facility, nprehensive care plan,					
	interviews, the facility physician's order for t urinary catheter for 1	ew, staff and physician failed to obtain a he use of an indwelling of 1 sampled residents atheter use (Resident		Resident #303 was discharged on 8/31/2017 and has not returned to the facility. The Director of Nursing or designee wi review the facility's current Residents identified with indwelling catheters to ensure physician orders are in place.	ill		
	admitted to the facility diagnoses which inclu Hyperplasia (enlargen which is a gland locat history of Cerebral Va	ed Resident #303 was y on 8/15/2017 with uded Benign Prostatic ment of the prostate gland, red below the bladder) and a uscular Accident (stroke). ion Minimum Data Set		The Director of Nursing or designee wi re-educate all licensed nursing staff or the facilities policy requiring a physicia order prior to inserting an indwelling catheter. The Director of nursing or designee will audit 2 patients who have indwelling catheter to ensure the appropriate physicians order weekly tin 4 weeks then monthly times 3 months.	n n's e an mes		

Facility ID: 922984

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						D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	SURVEY PLETED
					С	
		345343	B. WING		01/	/12/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH AND REI	HABILITATION/GOLDSBORO	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 658	Continued From page	e 8	F 658			
		ersons with activities of daily ated the resident was bowel and bladder.		weekly times 4 weeks then month 3 months and all negative findings addressed and further education as needed.	s will be	
	documentation by Nu PM which indicated F the beginning of the 3 were: blood pressure respirations 20, temp Fahrenheit and his ov between 80% and 84 indicated the Physicia were obtained for lab urine specimen for Ur of urine) and Culture which may grow and The note indicated th catheterized for the u note reported the resi 6:00PM and the vital blood pressure 93/56 temperature 98.6 and to 89% with oxygen in there was blood return there was no urine up catheter was left in pl	nursing notes revealed rse #1 on 8/29/2017 at 9:18 Resident #303's vital signs at 3:00PM to 11:00PM shift 113/74, pulse 116, erature 100.3 degrees kygen saturation ranged % on room air. The note an was notified and orders oratory tests including a rinary Analysis (UA-analysis and Sensitivity (C&S-a test identify bacteria in urine). e resident was straight rine sample. The nursing ident was catheterized at signs at that time were: , pulse 104, respirations 20, d oxygen saturation was 84% n place. The note revealed ned upon catheterization, oon catheterization and the ace. The note indicated the ar in distress and family was				
	note and orders dated note indicated the res physician. The progre resident had a low-gr was 87% on room air	ade fever, oxygen saturation , blood pressure was ear, heart rate was regular,				

	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F	CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN				PLETED
						(С
		345343	B. WING			01/	12/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH AND REI	HABILITATION/GOLDSBORO			700 WAYNE MEMORIAL DRIVE		
				G	OLDSBORO, NC 27534		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	`	CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
E 050							
F 658	Continued From page		F 6	58			
		n's orders included to obtain for a CBC, CMP and UA					
	with C&S.	TO A CBC, CMF and DA					
		nursing notes revealed a					
		Nurse #2 on 8/30/2017 at					
		licated Nurse #2 was called om and upon entry noted					
		and cool to touch. The note					
	-	e was a large amount of					
		and the catheter tubing. The					
	•	were documented in the note					
		3/56, pulse 104, temperature and his oxygen saturation					
	was 88% to 89%. The						
	resident's family was						
	requested the resider						
	emergency departme						
	documentation reveal notified and the reside						
	ambulance at 12:10 A						
		lable for interview during the					
	investigation.						
	Review of the hospita	Il records dated 8/30/2017					
		03 was evaluated in the					
	emergency departme	nt on 8/30/2017 at					
		AM. The documentation					
		arrived to the emergency					
	place and blood note	dwelling urinary catheter in					
		a in the dramage bag.					
	An interview was con	ducted with Nurse #1 on					
		Nurse #1 reported she					
		t #303 and cared for him on					
		stated when a resident is is ordered, she used an in					
		otain urine for the specimen.					

Facility ID: 922984

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 02/21/2018 APPROVED . 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE : COMPI	SURVEY _ETED
	345343	B. WING		_	01/1) 12/2018
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
BRIAN CENTER HEALTH AND REH	ABILITATION/GOLDSBORO		700 WAYNE MEMORIAL I GOLDSBORO, NC 2753			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
she placed an indwellin #303 on 08/29/17. Nurs did not recall calling the for the indwelling cathe physician she would ha An interview was condu- 1/12/2018 at 9:40AM. The not recall Resident #300 if he ordered a UA and resident, he would exp- an in and out catheter for The Physician stated if procedure did not prod catheter could be used greater than 400 millilit in. The Physician indica expect the catheter pla if there was no urine in hours post insertion an blood in the collection b Another interview was on 1/12/2018 at 10:10A surveyor and stated sh the evening since the p remembered the physic assessed the resident of 8/29/2017. Nurse #1 re her to catheterize the rn sample and she forgot #1 indicated she still di an indwelling urinary ca out catheter for the coll also indicated she did r	e did not remember why ag catheter for Resident se #1 further indicated she e physician to get an order eter, and if she called the ave documented it. ucted with the Physician on The Physician stated he did 3. The Physician indicated C&S for an incontinent ect the nursing staff to use to obtain the specimen. the in and out catheter uce urine, an indwelling and if the urine return is ers to leave the catheter ated he would certainly cement to be reevaluated the collection bag within 2 d with the presence of only bag. conducted with Nurse #1 AM. Nurse #1 called this e had been thinking about previous interview and cian was in the facility and on the evening of eported the physician told esident for the urine to write the order. Nurse d not recall why she used atheter instead of an in and lection of urine. Nurse #1 not recall if the physician elling urinary catheter, but	F 658				

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OLITILI		MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		345343	B. WING		01/12/2018
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN CE	NTER 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 658	Continued From page	e 11	F 658	3	
		ducted with the Director of			
	Nursing (DON) on 1/1	12/2018 at 10:30AM. The			
		ctation was a Physician's			
		d written along with the			
	-	welling urinary catheter.	_		0.0440
F 689 SS=D	CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 689		2/9/18
	§483.25(d) Accidents				
	The facility must ensu				
	•	sident environment remains			
		azards as is possible; and			
		esident receives adequate			
	supervision and assis accidents.	stance devices to prevent			
		is not met as evidenced			
	by:				
		n, staff interview and record		Resident #75's call bell was replaced	d by
		led to maintain a hazard free		the Maintenance Director on 1/11/20	
		of 112 resident call bell		The Administrator or designee will au	
		to have exposed wires		of the facility's call bell cords to ensur	re
	(Resident #75). Findings included:			they do not exhibit exposed wires. The Administrator or designee will	
				re-educate all facility staff on the facil	lities
	A review of medical re	ecords revealed Resident		expectation of observing patient	
	#75 was admitted 10/	7/2016 with diagnoses of		equipment while in a patient's room a	and
		Pulmonary Disease, Bi polar		the appropriate reporting method to i	
	-	n syndrome, anxiety, tobacco		Administration of an item needing rep	
	use and epilepsy.			The Administrator or designee will au 10-15 rooms per week then 10-15 per	
	The 5 day Minimum [Data Set (MDS) dated		month times 3 months, to ensure call	
		ident #75 to be cognitively		cords do not have any exposed wires	
		tensive to total assistance		The call bell cord audit results will be	
		ily Living, with the physical		reviewed by the facility's QAPI team	
	help of one person.			weekly x 4 weeks then monthly times months and all negative findings will	
	On 1/9/2018 at 10:34	AM during an interview		addressed and further education prov	

Facility ID: 922984

If continuation sheet Page 12 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE		
		345343	B. WING			C 01/12/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO			17	700 WAYNE MEMORIAL DRIVE				
	NIER REALIN AND REP	ABILITATION/GOLDSBORO		G	OLDSBORO, NC 27534			
(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 689	turn on her call bell. V up the call bell it was inches of the wiring in exposed. This was jus resident would hold to wires were insulated, wires went into the ha seen. The call bell was obse AM, to be in the same wires exposed. An observation was n call bell for Resident a repaired with no expo In an interview at 10:0 Maintenance Director call bell cord the night Maintenance Director types of cords have the wrapped around the be expose the wires. The stated he had repaire past. The Maintenance not audit call bell cord facility because he wo time. The Maintenance logbook at each nursi were signed in, and h the day, made repairs book when the repairs book when the repairs the call bell cords would the call bell	e Resident was asked to When Resident #75 picked observed to have 1 ½ iside the cord cover at below the handle where a o turn the call bell on. The but at the point where the andle the wires could be erved on 1/10/2018 at 11:00 a condition with the insulated hade on 1/11/2018 of the #75. The call bell was ised wiring. D0 AM on 1/11/2018, the stated he had repaired the t before (1/10/2018). The stated these particular his problem when they are bed rail and get pulled and a Maintenance Director d the call bell cords in the ce Director indicated he did is routinely throughout the orked alone and did not have the Director stated there is a ng station where problems e reviewed them throughout a and dated and signed the s were finished. PM in an interview, the stated his expectation was	F	689	as needed.			
	facility Administrator s	stated his expectation was						

If continuation sheet Page 13 of 22

DEPARTMENT OF HEALTH AND HUN CENTERS FOR MEDICARE & MEDIC					FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR	OVIDER/SUPPLIER/CLIA	` '		CONSTRUCTION	(X3) DATE COMF	
	345343	B. WING				 12/2018
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
BRIAN CENTER HEALTH AND REHABILI	AN CENTER HEALTH AND REHABILITATION/GOLDSBORO			00 WAYNE MEMORIAL DRIVE DLDSBORO, NC 27534		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 690 Bowel/Bladder Incontinence SS=D CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility muresident who is continent of admission receives services maintain continence unless for condition is or becomes such not possible to maintain. §483.25(e)(2)For a resident incontinence, based on the moment of admission receives assessment ensure that- (i) A resident who enters the indwelling catheter is not catheterization was necessal (ii) A resident who enters the indwelling catheter or subset is assessed for removal of the as possible unless the resided demonstrates that catheterizand (iii) A resident who is incontinece to the extent possible continence to the extent possible continence, based on the moment of admission receives appropriate treatment incontinence, based on the moment of the aspossible unless the resided demonstrates that catheterizand (iii) A resident who is incontinece to the extent possible continence to the extent possible. S483.25(e)(3) For a resident incontinence, based on the moment of a spossible. This REQUIREMENT is not by:	ust ensure that bladder and bowel on and assistance to his or her clinical h that continence is with urinary resident's , the facility must facility without an theterized unless the lemonstrates that rry; e facility with an quently receives one he catheter as soon ent's clinical condition ration is necessary; ment of bladder ent and services to ns and to restore sible. with fecal resident's , the facility must s incontinent of bowel ent and services to re function as	F	590			2/9/18

Facility ID: 922984

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE (CONSTRUCTION	(X3) DA	NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		CO	MPLETED
		345343	B. WING			C 01/12/2018	
NAME OF P	ROVIDER OR SUPPLIER		- I T	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				170	00 WAYNE MEMORIAL DRIVE		
	N CENTER HEALTH AND REHABILITATION/GOLDSBORO			GC	OLDSBORO, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	Continued From page	e 14	F 69	90			
	interviews, the facility	/ failed to evaluate an			facility on 8/30/2017 and has not retu	rned.	
	indwelling urinary cat	heter for proper placement			The Director of Nursing or designee w		
		blood in the drainage bag			audit all Residents who have had an		
	and no urine output v				indwelling catheter placed within the		
	-	maturia (blood in urine) for 1			30 days to ensure proper placement a	and	
	of 1 resident reviewe (Resident #303).	d for unnary catheter			appropriate drainage. The Director of Nursing or designee v	vill	
	(1403/00/).				re-educate all licensed staff on the	viii	
	Findings included:				facility's indwelling catheter insertion		
	-				policy. The Director of Nursing or		
		led Resident #303 was			designee will audit 3-4 patients who h	ave	
	admitted to the facilit			indwelling catheters to ensure proper			
	•	uded Benign Prostatic ment of the prostate gland,			placement and drainage weekly times weeks then monthly times 3 months.	64	
		ted below the bladder) and a			The indwelling catheter audit results	vill	
	-	ascular Accident (stroke).			be reviewed by the facility's QAPI tea		
	-				weekly times 4 weeks then monthly ti	mes	
		sion Minimum Data Set			3 months and all negative findings wi		
	. ,	17 indicated the Resident			addressed and further education prov	vided	
	required the assistan	cognitively impaired and			as needed.		
		g. The MDS indicated the					
	•	incontinent of bowel and					
	bladder.						
	Record review of the	nursing notes revealed					
		Irse #1 on 8/29/2017 at 9:18					
		Resident #303's vital signs at					
		3:00 PM to 11:00 PM shift					
	were: blood pressure	e 113/74, puise 116, erature 100.3 degrees					
		xygen saturation ranged					
		% on room air. The note					
		an was notified and ordered					
	-	s including a urine specimen					
		UA-analysis of urine) and					
		ty (C&S-a test which may					
	grow and identify bac indicated the residen	cteria in urine). The note					

If continuation sheet Page 15 of 22

	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/21/2018 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345343	B. WING			C / 12/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			·	1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	INTER HEALTH AND REP	ABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 690	reported the resident and there was blood r catheterization, there catheterization and th The note indicated the distress and family wa Record review reveals note and orders dated note indicated the res physician. The progre resident had a low-gra was 87% on room air 106/64, lungs were cl abdomen was soft, no present and the reside stimuli. The Physician a laboratory specimer Further review of the note documented by I 8:07 AM. The note ind to Resident #303's root the resident was pale further indicated there blood in the catheter of catheter tubing. The r documented in the no pulse 104, temperatur his oxygen saturation revealed the resident	6:00 PM. The nursing note was catheterized at 6:00PM returned upon was no urine upon e catheter was left in place. e resident did not appear in as at the bedside. ed a Physician's Progress d 8/29/2017. The progress ident was seen by the as note detailed the ade fever, oxygen saturation blood pressure was ear, heart rate was regular, be edema (swelling) was ent responded to verbal r's orders included to obtain of for a UA with C&S nursing notes revealed a Nurse #2 on 8/30/2017 at dicated Nurse #2 was called om and upon entry noted and cool to touch. The note e was a large amount of drainage bag and the esident's vital signs were te as: blood pressure 93/56, re 98.6, respirations 20 and was 88% to 89%. The note s family was at the bedside sident to be sent to the nt for evaluation. The ed the physician was ent left the facility by	F 690			
	ambulance at 12:10 A					

Facility ID: 922984

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
	CONTROLION	DENTIFICATION NUMBER.	A. BUILDING	3		
						С
		345343	B. WING			1/12/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
		HABILITATION/GOLDSBORO		1700 WAYNE MEMORIAL DRIVE		
	NIER HEALTH AND RE	HABILITATION/GOLDSBORD		GOLDSBORO, NC 27534		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
F 690	Continued From page	e 16	F 69	90		
	#303 was evaluated i					
		3/30/3017 at approximately				
		dmitted to the hospital with				
		nematuria. The hospital				
		resident arrived to the ED				
		nary catheter with blood				
		age bag. The hospital				
		ate anything about the				
		lling catheter. The hospital				
		order for a STAT (immediate)				
		ned. The records indicated				
		tained from a clean catch				
	-	ive and obtained from				
		ontainer as opposed to a				
		ults were documented at				
	2:15 AM on 8/30/201					
		ducted with Nurse #1 on				
		1. Nurse #1 reported she				
		nt #303 and confirmed she				
		0/17 from 3:00 PM to 11:00				
		d when a resident was				
		was ordered, she used an in				
		btain urine for the specimen.				
		he did not remember why				
		ling catheter in Resident see #1 recalled inserting the				
		u				
		here was not any unusual catheter was inserted. Nurse				
		s blood return in the tubing				
		id no urine in the collection				
		#1 further indicated although				
		sident for the rest of the				
		not reevaluate the catheter				
	-	e #1 indicated there was no				
	-					
		bag from 6:00 PM until the				
	end of her shift at 11:	00 PM. Nurse #1 stated she the physician and inform him				

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345343	B. WING				C / 12/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BRIAN CE	NTER HEALTH AND REP	HABILITATION/GOLDSBORO			700 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 690	the urinary collection there was a lot going forgot to call him. Nur the resident's condition all evening, so the lac collection bag did not #1 indicated she did r shared during the shift nurse on 8/29/2017. Nurse #2 was unavail investigation. An interview was com 1/12/2018 at 9:40 AM did not recall Residen indicated if he ordered incontinent resident, f staff to use an in and specimen. The Physic catheter procedure di indwelling catheter co return is greater than catheter in. The Physic certainly expect the co reevaluated if there w bag within 2 hours po presence of only bloo Physician also indicat notified of the absence of blood in an indwelli speculate as to what have been. An interview was com- Nursing (DON) on 1/1 DON indicated the ex catheters to be used to	bag because she recalled on that evening and she just se #1 stated she recalled on was essentially the same sk of urine in the urinary seem to affect him. Nurse not recall the information she ft report with the oncoming able for interview during the ducted with the Physician on . The Physician stated he tt #303. The Physician d a UA and C&S for an ne would expect the nursing out catheter to obtain the cian stated if the in and out d not produce urine, an build be used and if the urine 400 milliliters to leave the ician indicated he would atheter placement to be as no urine in the collection st insertion and with the d in the collection bag. The red he expected to be e of urine and the presence ing catheter, but could not his course of action would	F	690			

Facility ID: 922984

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE COMF		
		345343	B. WING			01/12/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	·		
BRIAN CE	INTER HEALTH AND REP	HABILITATION/GOLDSBORO			AYNE MEMORIAL DRIVE SBORO, NC 27534			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 690 F 761 SS=D	stated the expectation catheters to be reason blood and the absence placement. The DON unaware of the reason indwelling catheter for indicated informing th with the absence of u catheter was expected catheter placement w Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals labeled in accordanced professional principles appropriate accessory instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci- biologicals in locked of temperature controls, personnel to have accor §483.45(h)(2) The faci- locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 an abuse, except when the package drug distribut quantity stored is min	n was for indwelling essed with the presence of the of urine to ensure correct further stated she was in Nurse #1 utilized an r Resident #303. The DON e Physician for guidance rine from an indwelling d as reevaluation of the as warranted. d Biologicals (1)(2) of Drugs and Biologicals to used in the facility must be with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized	F 6				2/9/18	
	Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when the package drug distribution	lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cess to the keys. clity must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the						

Facility ID: 922984

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/21/2018 M APPROVED O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
		345343	B. WING			C / 12/2018
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	by: Based on observatio	is not met as evidenced	F 7(The Purified Protein Derivative		
	medications or biolog medication storage re Findings included: During the medication	frigerators reviewed.		the Calcium Carbonate were im discarded by the Director of Nur The Director of Nursing or desig audit all nurses carts and medic storage areas to ensure all oper medications are dated and medic	rsing. Inee will ation ned	
	1/12/2018 at 1:45 PM of Purified Protein De for Tuberculosis testin refrigerator in the me	l, a bagged, multi-dose vial rivative (PPD) which is used ng, was noted to be in the dication storage room on the		have not expired. The Director of Nursing or Designed re-educate all licensed staff on f facility's policy regarding medica	gnee will the ation	
	expiration date was 0 and no date was on t containing the boxed	number was 301013 and the 2/19. The vial was opened he vial, the box or the bag vial. There was a sticker on ted for the open date, but no		storage to include proper dating observing expiratory dates. The of Nursing or designee will audi medication storage areas to en- opened medications are dated a medications have not expired w times 4 weeks then monthly tim	e Director t 2-3 sure all and all eekly	
	300 hall medication c container of Calcium lot number 31608 and 10/17.	PM, during a review of the art, there was a large Carbonate chewable tabs, d an expiration date of	there was a large bonate chewable tabs,		sults will PI team nthly times gs will be n provided	
F 867	stated her expectatio dated when it was op	nt back to the pharmacy or	F 8	57		2/9/18
SS=D	CFR(s): 483.75(g)(2)					
	§483.75(g)(2) The qu assurance committee	ality assessment and must:				
			1	1		

Facility ID: 922984

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>		· · ·	IPLETED
			A. BOILDING			С
		345343	B. WING		0	1/12/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		1/12/2010
				1700 WAYNE MEMORIAL DRIVE		
BRIAN CE	NTER HEALTH AND RE	HABILITATION/GOLDSBORO		GOLDSBORO, NC 27534		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETIO
F 867	Continued From pag	e 20	F 86	7		
		ement appropriate plans of				
		tified quality deficiencies;				
		T is not met as evidenced				
	by: Based on observation	on, staff and resident		The facility QAPI team to	include the	
		d review, the facility Quality		Administrator, Director of I		
		surance (QAA) Committee		managers, Social Worker,		
		plemented procedures put		Manager and Dietary Mana		
	-	These interventions were in		provided re- education reg		
		ed in the recertification survey		Quality Assurance and Per		
		and F315) and recited in the		Improvement process by d	istrict clinical	
	recertification survey	the areas of services to meet		Director. Resident #303 was dischar	and from the	
		ds and bowel/bladder		facility on 8/30/2017 and ha		
		r. The continued failure of		The Director of Nursing or		
		consecutive federal surveys		audit all Residents who have		
	of record show a pat	tern of the facility's inability to		indwelling catheter placed		
	sustain an effective (QAA program.		30 days to ensure proper p	lacement and	
				appropriate drainage.		
	Findings included:			The Director of Nursing or re-educate all licensed staf	0	
	This citation is cross	referenced to:		facility's indwelling catheter		
				policy. The Director of Nur		
	1)F281-Based on rec	cord review and staff		designee will audit 3-4 pati	-	
	-	ailed to obtain a laboratory		indwelling catheters to ens		
	blood test for a Basic	Metabolic Panel as ordered		placement and drainage w		
		1 of 5 residents reviewed for		weeks then monthly times		
	unnecessary medica	tions.		The indwelling catheter au		
	The facility was sited	during the 11/10/2016		be reviewed by the facility's		
	-	during the 11/10/2016 for failure to obtain a		weekly times 4 weeks then 3 months and all negative f	-	
		as ordered by the physician.		addressed and further edu	-	
	•	rvey, the facility failed to		as needed.		
	-	order for an indwelling		The District director of clini	cal services	
	catheter.	5		and/or district director of or	peration will	
				attend the facility QAPI me		
	-	cord review, observation and		times 3 months to ensure in	-	
	staff and resident inte	erview the facility failed to		procedures are appropriate	ely maintained.	

Facility ID: 922984

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/21/2018 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345343	B. WING				C 12/2018
NAME OF F	NAME OF PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
BRIAN CI	ENTER 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	to maintain or preven incontinent episodes The facility was cited recertification survey scheduled toileting to incontinence. During facility failed to evalue catheter for proper pla During an interview w 01/22/2018 at 4:00 Pl the QAA Committee r developed and implei correct identified qual Administrator also star recertification survey, in place and until this	t decline of urinary for 1 of 2 residents. during the 11/10/2016 for failing to provide prevent decline in urinary the current survey, the ate an indwelling urinary acement. with the Administrator on M, the Administrator stated net monthly and identified, mented plans of action to	F	867	DEFICIENCY)		

If continuation sheet Page 22 of 22