PRINTED: 09/21/2018 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345265	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	040200	5:0_	STREET ADDRESS, CITY, STA	ATE ZID CODE	08/09/2018	
NAIVIE OF PI	ROVIDER OR SUPPLIER						
BRIAN CE	NTER HEALTH & REHAI	В/ҮА		1086 MAIN STREET NORTH YANCEYVILLE, NC 2737			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		
	Comprehensive Asse CFR(s): 483.20(b)(1)(1)(1)(1)(2)(1)(2)(1)(2)(1)(1)(2)(2)(1)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)(2)	ssments & Timing (2)(i)(iii) sessment duct initially and periodically curate, standardized nent of each resident's ensive Assessments ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least lemographic information s. or patterns. ll-being. ling and structural problems. e and health conditions. onal status.  tts and procedures.		CROSS-REFEREN		9/11/18	
	on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The ass	gered by the completion of the time (MDS).					
ARODATORY I		SUPPLIER REPRESENTATIVE'S SIGNATUR	) PE	TITLE		(X6) DATE	

Electronically Signed 08/31/2018

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.

Facility ID: 923000

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345265	B. WING				09/ <b>2018</b>
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	09/2016
BRIAN CE	NTER HEALTH & REHA	В/ҮА			086 MAIN STREET NORTH 'ANCEYVILLE, NC 27379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 636	Continued From page	e 1	F	636			
	• •	well as communication with					
	members on all shifts						
		required. Subject to the d in §413.343(b) of this					
		st conduct a comprehensive					
		dent in accordance with the					
	-	in paragraphs (b)(2)(i)					
		ction. The timeframes 43(b) of this chapter do not					
	apply to CAHs.						
		(i) Within 14 calendar days after admission,					
		ns in which there is no					
	_	the resident's physical or					
		r purposes of this section,					
		a return to the facility					
	or therapeutic leave.)	absence for hospitalization					
	(iii)Not less than once						
		is not met as evidenced					
	by:	iew and staff interviews, the			Preparation and/or execution of this Pl	an	
	facility failed to accura	•			of Correction does not constitute	an	
		ssment for the resident 's			admission by the provider of the truth of	f	
		sampled residents reviewed			facts alleged or the conclusions set for		
	for assessments (Res	sident #60).			in the statement of deficiencies. This pl	an	
					of correction is prepared and/or solely		
	Findings included:				because it is required by the provision the Federal & State Law.	of	
	Resident #60 was ad	mitted to the facility on			F 636		
		ty diagnoses were epilepsy,			1. The plan of correcting the specific		
		avioral disturbance, fracture			deficiency. The plan should address the	е	
		es, anxiety, and generalized			process that lead to the deficiency.		
	muscle weakness.				a) The Resident Care Management		
					Director (RCMD) or designee will		
	The physician order of				complete an audit of current residents		
	Buspirone HCL 5 mg				receiving an Omnibus Budget	h a	
	(anti-anxiety medicati	on).			Reconciliation Act Assessment during t	ne	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345265	B. WING		C 08/09/2018
	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	30.00.20.0
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 636	(MDS) assessment of resident had adequal was understood and was unable to be assideficit. The resident resident required ext for transfer and one daily living (ADL) excactive diagnoses we dementia, seizure diasthma.  A review of Resident 7/8/18 revealed goal emotional and intelled behavior and communicognition, psychotroganti-psychotic and arrisk for respiratory complete of the resident was not quarterly 6/28/18 METhe resident had the receiving anxiety method.  On 8/9/18 at 3:45 pm with the facility Directived.	rterly Minimum Data Set dated 6/28/18 revealed the te hearing, clear speech and understands. Her cognition sessed secondary to memory had no behaviors. The tensive assistance of 2 staff staff for all other activities of cept meals were set up. The re non-Alzheimer's sorder, schizophrenia, and at #60's care plan dated and interventions for extual needs, ADL deficit, unication deficit, impaired pic medication for noti-anxiety, seizure, and at complications.  In an interview was MDS Nurse who stated that coded for anxiety on the DS and should have been.	F 636	last fourteen days to verify accurate coding of Section I of the Minimum D Set (MDS) per the Resident Assessm Instrument (RAI) Manual guidelines. needed, modifications will be comple by the RCMD and or MDS Designee the RAI Manual guidelines. Resident had a modification of section I to reflet the appropriate diagnosis for Assessi Reference Date 6/28/18. The process breakdown occurred when the coding the Minimum Data Assessments did a correspond with the Resident Assess Instrument Manual.  2. The procedure for implementing acceptable plan of correction for the specific deficiency cited.  a) District Director Care Manageme will provide education to the Interdisciplinary Team members who participate in MDS coding of sections related to accurate coding of MDS according to the RAI Manual on September 4, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five rai MDSs monthly for 3 additional month verify accurate coding of Section I of MDS. One to one education will be provided if opportunities for correction are as identified as a result of these audits. Modifications to the MDS will completed as needed.  3. The monitoring procedure to ensithat the plan of correction is effective that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.  a) The results of these audits will be	nent  If  Ited  Ited  If  If  If  If  If  If  If  If  If  I

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	IP CODE	00/03/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIAT	DATE
F 636	S483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this section means a major declir resident's status that itself without further in implementing standar interventions, that ha one area of the resider requires interdiscipling care plan, or both.) This REQUIREMENT by:  Based on record revision for the second	essment After Signifcant Chg (ii) nin 14 days after the facility d have determined, that	F6	presented by the Reside Management Director months at Facility Quality Performance Improvemed Committee Meeting. The Committee will make charecommendations as incomplementing the accepanal of the Resident Care Director is responsible from any sustaining the planations. Dates when correct completed. The corrections be acceptable to the any September 11, 201.	nonthly for 6 by Assurance ent (QAPI) e QAPI anges or dicated. onsible for table POC. Management or implementing of correction. live action will be we action dates ne State. 8	9/11/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345265	B. WING			C <b>08/09/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00/09/2010
TO UNIC OF T	NOVIDER OR COLL FIER			1086 MAIN STREET NORTH	0052	
BRIAN CE	NTER HEALTH & REH	AB/YA		YANCEYVILLE, NC 27379		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 637	Continued From pag	ge 4	F 6	337		
	residents reviewed f (Resident #37).	or significant change		facts alleged or the conclu in the statement of deficient of correction is prepared a	ncies. This pland/or solely	an
	Findings included:			because it is required by the Federal & State Law.	he provision of	of
	diagnoses psychotic unknown physiologi depressive disorder hypercalcemia, adju	, Chron ' s disorder, stment insomnia and anxiety,		F 637  1. The plan of correcting deficiency. The plan shoul process that lead to the deal) The Resident Care M	ld address the eficiency. lanagement	e
	disease.	ne, and Huntington ' s t #37 ' s quarterly Minimum		Director (RCMD) or design complete an audit of all cu who received Hospice Ser six months to ensure that	urrent resident rvices in the la	
	resident had adequa	ed 5/26/18 revealed the ate hearing, unclear speech, od or understands. The		Change in Status Assessn completed within 14 days change in status per the R	following the	n
	cognition was sever	ely impaired and there was no ors. The resident required		Assessment Instrument (Figuidelines, If needed, mod	RAI) Manual	be
	extensive assistance	e of two staff for all transfers other activities of daily living		completed by the RCMD a	and or MDS	
	(ADL). The active d	iagnoses were anemia, ementia, Huntington 's		Resident #37 had a Signifi Status Assessment comple	ficant Change	
		sphagia, Chron 's disease,		Assessment Reference Da reflect Hospice Services.	ate of 8/8/18 t The process	
	I .	e plan dated 5/30/18 review interventions for dependent		breakdown occurred wher the Minimum Data Assess correspond with the Resid	sments did no	t
	for emotional and in	tellectual needs, ADL deficit, communication and cognitive		Instrument Manual.  2. The procedure for imp		
	deficit, high risk for the anti-anxiety and anti-	falls, gastrointestinal deficit, i-depressant medication, and nutritional decline.		acceptable plan of correct specific deficiency cited.  a) District Director Care	tion for the	
	Physician order date and order dated 7/9	ed 7/3/18 for hospice services /18 for oxygen 3 liters per lortness of breath and		will provide education to the Interdisciplinary Team mer participate in selecting app Assessment types and Assessment types according Manual on September 4, 2	he mbers who propriate ssessment ng to the RAI	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	L COME	
		345265	B. WING _			C <b>08/09/2018</b>
	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP COI 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 637	A review of Resident was updated on 7/3/services. There were Hospice services do interventions found from N/1/18 at 10:30 at with NA #12 who state sitting/supervising Redecline in nutritional increased confusion resident a high risk from the resident was plangly.  On 8/7/18 a review of Data Set record since no significant change on 8/9/18 at 11:30 at conducted with the Resident #37 did no assessment, it was a should have had an the Hospice order date.  On 8/9/18 at 3:45 prowith the Director of Nexpected an assess	ed 7/3/18 for Morphine 5 all every 2 hours as needed.  It #37 's care plan revealed it 1/18 to reflect Hospice re no interventions for cumented and no goals or for significant change.  In interview was conducted atted she was resident #37 who had a resident with weight loss and from dementia making the for fall. NA #12 stated that ced on Hospice services in who was resident #37 's Minimum received was reassessment completed.  In an interview was who stated that thave a significant change overlooked. The resident assessment within 14 days of	F 6	RCMD will randomly audit five MDSs weekly for 12 weeks at random MDSs monthly for 3 months to verify that resident Hospice Services have an application of Significant Change in Status completed within 14 days following in status per the Resident Assessment Instrument (RAI guidelines. One to one educated provided if opportunities for care as identified as a result of audits. Modifications to the Modification of the Interdisciplinary Teal that MDS has received known Hospice conversion, thus alled MDS Team to schedule approving the Modification of the Province Services.  3. The monitoring procedulation of the Province Services and for in complian regulatory requirements.  a) The results of these auditions are proving the Resident Committee Modification of the Province Improvement (Committee Meeting. The QA Committee Will make change recommendations as indicated the Title of person responsibility and the Province Improvement (Committee Will make change recommendations as indicated the Title of person responsibility and the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated the Province Improvement (Committee Will make change recommendations as indicated th	and then five additional t's receiving opropriate Assessment lowing the sident ) Manual ation will be corrections of these MDS will be esident es will be or in the Daily ru Friday, m to ensure dedge of the owing the opriate s to capture re to ensure effective and d remains ce with the lits will be are ly for 6 surance QAPI) PI es or ed. ole for	
				implementing the acceptable a) The Resident Care Mar	POC.	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION  IG	l <sup>(x</sup>	3) DATE SURVEY COMPLETED
		345265	B. WING _			C 08/09/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 637	Continued From pag	e 6	F 6	Director is responsible for impand sustaining the plan of corrective accompleted. The corrective actimust be acceptable to the Staa) September 11, 2018	rection. tion will be on dates	
F 641 SS=E	resident's status.		F 6			9/11/18
	facility failed to accur Data Set (MDS) assed diagnoses for 2 of 31 and Resident #10), to of 31 residents (Resistatus for 1 of 31 res reviewed for the accur The findings included 1) Resident #63 was re-entry to the facility 8/16/17. The reside diagnoses included a heartbeat that increa heart disease), anem condition that causes on chronic systolic (con A review of Resident included a provider p Nurse Practitioner or	admitted on 9/20/12 with		Preparation and/or execution of Correction does not constitut admission by the provider of the facts alleged or the conclusion in the statement of deficiencie of correction is prepared and/of because it is required by the puthe Federal & State Law. F 641  1. The plan of correcting the deficiency. The plan should accord process that lead to the deficiency. The Resident Care Manage Director (RCMD) or designed complete an audit of current repreceiving an Omnibus Budget Reconciliation Act Assessmen last 14 days to verify accurate Sections A, I and N of the Minister (MDS) per the Resident Assessment (RAI) Manual guide needed, modifications will be oby the RCMD and or MDS Destite RAI Manual guidelines. Resident RAI Manual guidelines.	ate the truth of the set forth the specific the set forth	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345265	B. WING _				C ( <b>09/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER	<b>L</b>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2010
					086 MAIN STREET NORTH		
BRIAN CE	NTER HEALTH & REH	AB/YA			ANCEYVILLE, NC 27379		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 641	Continued From pag	ae 7	F	341			
		/18/15 and noted as active,		• • •	had modification of section I to reflect		
	,	nset 10/18/15 and noted as			accurate medical diagnoses for		
	, ,	d congestive heart failure			Assessment Reference Date 6/29/18.		
		I noted as active, chronic).			Resident #10 had a modification of		
	(Onset Tor Tor To alle	Thota as active, cinomoj.			section I to reflect accurate coding of the	ne l	
	A review of Residen	it #63 's most recent quarterly			medical diagnoses for Assessment		
		(MDS) assessment dated			Reference Date 5/11/18. Resident #8	33	
		eted. Section I of the MDS			had a modification of section N for		
	· •	include a diagnosis of atrial			Assessment Reference Date 7/7/18 to		
	fibrillation, anemia,	_			reflect the accurate coding of		
					medications. Resident #124 had a		
	An interview was co	onducted on 8/9/18 at 11:30			modification of section A for Assessme	nt	
	AM with the facility '	s MDS Nurse. During the			Reference Date 6/16/18 to reflect the		
	interview, the nurse	was asked to review Section I			residents accurate discharge location.		
	of the 6/29/18 quart	erly MDS assessment for			The process breakdown occurred when	n	
	Resident #63. Upor	n review of the MDS, the			the coding of the Minimum Data		
	nurse confirmed atri	ial fibrillation, anemia, and			Assessments did not correspond with t	.he	
		ot checked as active			Resident Assessment Instrument Manu		
	_	esident. When the resident 's			<ol><li>The procedure for implementing the</li></ol>	ıe	
		reviewed, the nurse also			acceptable plan of correction for the		
		#63 had an active diagnosis			specific deficiency cited.		
		nd received Eliquis (an			a) District Director Care Managemen	t	
		art of his treatment; he had an			will provide education to the		
	_	anemia and received Niferex			Interdisciplinary Team members who		
		t) to treat it; and, the resident			participate in MDS coding of sections A		
		osis of heart failure and			and N related to accurate coding of ME	S	
		e (a diuretic) as part of his			according to the RAI Manual on		
		The nurse reported the			September 4, 2018. The RCMD will		
		lanned for atrial fibrillation and			randomly audit five completed MDSs	d aa	
		IDS Nurse stated the MDS			weekly for 12 weeks and then five rand		
	_	h the diagnoses, medications,			MDSs monthly for an additional 3 months verify accurate coding of Sections A		
	,	nurse reported she would			to verify accurate coding of Sections A and N of the MDS. One to one education		
	nave expected that,	"I would have coded it."			will be provided if opportunities for	ווכ	
	An interview was co	onducted on 8/9/18 at 3:09 PM			corrections are as identified as a result	of	
		irector of Nursing (DON).			these audits. Modifications to the MDS		
	_	r, concerns regarding the			be completed as needed.	VVIII	
	_	on the MDS assessments			The monitoring procedure to ensu	re	
		hen the DON was asked what			that the plan of correction is effective a		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP ( 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	CODE	0.000
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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) COMPLETION DATE
F 641	Continued From page her expectations we she stated she would diagnoses to be ider given and coded according to the facility of	re for the MDS assessment, dexpect the proper nitified for all medications curately on the MDS.  admitted on 1/4/18 with lity from the hospital on His cumulative diagnoses isorder.  #10 's medical record progress note signed by his in 4/4/18. The note indicated medical history which	F 6	DEFICIEN	cy)  dited remains ance with the sudits will be to Care of the control of the con	
	AM with the facility 'interview, the nurse of the 5/11/18 quarte Resident #10. Upon nurse confirmed "Se	Epilepsy."  Inducted on 8/9/18 at 11:30 Is MDS Nurse. During the was asked to review Section I erly MDS assessment for a review of the MDS, the izure Disorder or Epilepsy" an active diagnosis for this				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	X3) DATE SURVEY COMPLETED		
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F 641	was reviewed, the nuresident had a medic disorder and receive The nurse stated she "I would have coded An interview was corwith the facility 's Din During the interview, missing diagnoses o were discussed. Where expectations were she stated she would diagnoses to be identified given and coded according to the dated 7/7/18 indicated 7 doses of antipsychantidepressant, antificantibiotic, diuretic and Review of the medic (MAR) for the month had received 7 dose antidepressant only.  On August 9, 2018 a and record review with Resident #83 's MD	resident 's medical record arse also confirmed the cal history of a seizure delevetiracetam to treat it. et would have expected that, it."  Inducted on 8/9/18 at 3:09 PM rector of Nursing (DON).  I concerns regarding the enthe MDS assessments are the DON was asked what refor the MDS assessment, dexpect the proper stiffied for all medications curately on the MDS.  Is admitted on 1/20/17 with sein part of Alzheimer Mellitus, and hypertension.  Medical MDS assessments and medications curately on the MDS.	F6	41		

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  IG		X3) DATE SURVEY COMPLETED
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F 641	Continued From page	: 10	F 6	41		
	6/13/18 with diagnose	s admitted to the facility on es included acute respiratory art failure, diabetes mellitus, e stage 2.				
	note, dated 6/16/18, r discharged to anothe upon resident 's requ	nurse 's discharge progress evealed Resident #124 was r nursing facility on 6/16/18, lest. All belongings were s daughter who transported cility.				
	Record review of the assessment, dated 6/ #124 was discharged	16/18, revealed Resident				
	Summary, dated 6/15 had initiated the disch	ident 124 's Discharge /18, revealed the resident narge and was going to y. The document signed by				
	Nurse stated the residuscharged and was on 6/16/18. The nurse	discharged to another facility e stated the discharge MDS sident # 124 was incorrectly				
F 657 SS=D	Director of Nursing st the MDS nurses prov reflecting actual resid		F 6	57		9/11/18
	§483.21(b) Comprehe	ensive Care Plans				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NI IMBED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345265	B. WING _			C 08/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		00/00/2010	
DDIAN CE	NTED HEALTH & DEHAL	D/VA		1086 MAIN STREET NORTH			
BRIAN CE	NTER HEALTH & REHA	5/1A		YANCEYVILLE, NC 27379			
(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 CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPLICATION OF THE APP	OULD BE	(X5) COMPLETION DATE	
F 657	Continued From page	e 11	F6	57			
	1.7	orehensive care plan must					
	the comprehensive as (ii) Prepared by an infincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the r An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev	terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined e development of the e staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary					
	comprehensive and cassessments.	ssment, including both the quarterly review					
	This REQUIREMENT by:	is not met as evidenced					
	facility failed to revise reflect the significant of an anti-depressant residents reviewed fo Findings included: Resident #37 was ad	iew and staff interviews, the the resident 's care plan to change and discontinuance for 1 of 24 sampled or care plan (Resident #37).  mitted on 3/9/16 with the disorder with delusions from		Preparation and/or execution of to forcection does not constitute admission by the provider of the to facts alleged or the conclusions so in the statement of deficiencies. To forcection is prepared because required by the provision of the Foundative State Law. F657  1. The plan of correcting the sp	truth of set forth This plan e it is ederal &		
	unknown physiologica			deficiency. The plan should addre			

		(X3) DATE COMP	SURVEY PLETED				
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NAME OF PI	ROVIDER OR SUPPLIER						
BRIAN CE	NTER HEALTH & REHA	AB/YA			086 MAIN STREET NORTH		
				Υ	ANCEYVILLE, NC 27379		
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F 657	Continued From pag	je 12	F6	357			
	depressive disorder,	Chron 's disorder.			process that lead to the deficiency.		
	adjustment insomnia				a) The care plan for Resident #37 wa	as	
		.,			updated on August 28, 2018 by the		
	A review of physicial	n order revealed Lexapro 5			Resident Care Management Director		
	mg was discontinued	•			related to the significant change of state	tus	
	mg was alsoonanas	a on 0,00,11.			and discontinuance of anti-depressant		
	A review of Resident	t #37 ' s quarterly Minimum			therapy. All residents who have had		
		ed 5/26/18 revealed the			anti-depressant medication discontinue	ed	
		ate hearing, unclear speech,			will have their care plan audited by the		
	-	od or understands. The			Resident Care Management Director b		
		ely impaired and there were			August 31, 2018 to assure the care pla		
	_	aviors. The resident required			reflective of the current status. All		
		e of two staff for all transfers			residents who have had a significant		
		other activities of daily living			change in status assessment in the las		
		iagnoses were anemia,			90 days will have their care plan audite		
		ementia, Huntington ' s			and updated, as needed, by the Resid	ent	
		sphagia, Chron 's disease,			Care Management Director by August		
	abnormal weight los	s, insomnia, and Vitamin B12			2018 to assure the care plan is reflecti	ve	
	deficiency.				of the current status. It is alleged that t	he	
					facility failed to update a comprehensive	/e	
	Resident #37 's care	e plan dated 5/30/18 review			care plan for the discontinuance of		
	revealed goals and i	nterventions for dependent			antidepressant medication and with a		
	for emotional and int	tellectual needs, ADL deficit,			significant change in status assessmer	nt.	
		communication and cognitive			(Resident #37) The process that led to		
		alls, gastrointestinal deficit,			deficiency is Resident #37 plan of care	<del>)</del>	
	_	-depressant medication,			was not updated with change of		
	neurological deficit,	and nutritional decline.			medication and significant change of		
					status.		
		ed 7/3/18 for hospice services			2. The procedure for implementing the	те	
		18 for oxygen 3 liters per			acceptable plan of correction for the		
		ortness of breath and			specific deficiency cited.		
	hypoxia.				a) It is the policy of Brian Center of		
		170406 14 :: -			Yanceyville to ensure residents have c		
		ed 7/3/18 for Morphine 5			plans that reflect the resident □s currer		
	milligrams sublingua	l every 2 hours as needed.			status. Staff education provided by the		
	<u> </u>				Director of Nursing (DON) on August 3	Ю,	
		t #37 's care plan revealed			2018 to Resident Care Management		
		on 7/3/18 to reflect Hospice			Director and Minimum Data Set (MDS)	)	
	services began in Ju	lly. No goals or interventions			Coordinator on policy and procedure		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345265	B. WING _			08/	09/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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DRIAN CE	NTER HEALTH & REHAI	D/ TA		Y	ANCEYVILLE, NC 27379		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 13	F 6	357			
	were documented. Tintervention for signification discontinuance of an documented.  On 8/7/18 at 10:30 ar with Nursing Assistant sitting/supervising Referesident had a decline weight loss and incredementia making the NA #12 stated that the Hospice services in John S/7/18 a review of Data Set since 7/1/18 significant change astrigger a care plan up On 8/9/18 at 11:30 arconducted with the M Resident #37 did not assessment, it was on should have had an athe Hospice order dat corresponding changed discontinuance of the overlooked on the care.	here was no goal or cant change or for the anti-depressant  in interview was conducted t (NA) #12 who was sident #37 and stated the in nutritional intake with ased confusion from resident a high risk for fall. e resident was placed on uly.  Free Resident #37 's Minimum or revealed there was no sessment completed to date.  In an interview was DS Nurse who stated that have a significant change werlooked. The resident issessment within 14 days of the ded 7/3/18 and a ge in care plan. The anti-depressant was		557	regarding revising the resident scare plan to reflect the significant change ar the discontinuance of anti-depressant medication.  3. The monitoring procedure to ensure that the plan of correction is effective a that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.  a) The Resident Care Management Director will perform a documented aud of residents care plans after medication changes are ordered and with a Significant Change Assessment for 4 weeks, and then 10 random care plans weekly X 8 to ensure that the facility caplans are revised, as needed, to reflect the resident status.  b) The Resident Care Management Director will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up act determined by the QAPI team.  4. Title of person responsible for implementing the acceptable POC.  a) The Resident Care Management Director will be responsible for the implementation of the acceptable plan correction.	re nd dit ion	
	expected the care pla changes as needed.	•			<ul> <li>5. Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.</li> <li>a) September 11, 2018</li> </ul>		
F 684 SS=E	Quality of Care CFR(s): 483.25		F 6	684			9/11/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SI COMPLE	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 684	applies to all treatment facility residents. Bas assessment of a resident residents received accordance with proferactice, the comprehence plan, and the resident resident resident resident resident resident recipies. This REQUIREMENT by:  Based on record revinterviews, the facility order for isolation prereviewed for isolation and failed to appropriformula for 2 of 3 resifieding (Resident #251.  Resident #58 and the quarterly Minimurassessment, dated 751 cognition. His diagnoral Resistant Staphyloco infection) in his eyes.  Review of Resident 581/3/18, revealed that therapy and contact is to MRSA. The goal we discomfort or adverse therapy. The intervent medications as order maintain isolation corrections.	ndamental principle that and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered sidents' choices.  The is not met as evidenced sew, observation and staff failed to obtain physician 's caution for 1 of 2 residents precaution (Resident #58) ately label the tube feeding dents reviewed for tube and Resident #1).  In itted on 6/16/17. Review of an Data Set (MDS) (18/18, revealed his intact ses included Methicillin ccus Aureus (MRSA - 8 's plan of care, dated he received antibiotic solation precaution, related as to monitor/prevent eside effects of antibiotic tions were to administer end by physician and	F6	Preparation and/or ex of Correction does not admission by the provision the statement of def of correction is prepare required by the provision State Law. F684  1. The plan of correct deficiency. The plan state process that lead to thataly a process that lead to the process that the facility physician or precautions. Resident #1 currently feeding formula approalleged that the facility physician or process that led to the process that led to the	constitute ider of the truth o nclusions set fort ficiencies. This pl ed because it is on of the Federa cting the specific hould address the e deficiency. Tently has a Isolation ents who currently tions had their ed by the Director 2018 to assure order for the Resident #25 and have their tube priately labeled. I or failed to obtain a Isolation if #58) and that the ly label tube feed #25 and #1. The	e e e e e e e e e e e e e e e e e e e	

PRINTED: 09/21/2018 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		
		345265	B. WING			C / <b>09/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	1.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	09/2016
				1086 MAIN STREET NORTH		
BRIAN CE	NTER HEALTH & REHA	B/YA		YANCEYVILLE, NC 27379		
(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) COMPLETION DATE
F 684	Continued From pag	e 15	F 68	34		
	7/18/18 laboratory da 's eye infection with  Record review of phy readmission of Resid revealed the resident treatment of eye infe	ted 7/23/18, revealed at a results, indicated resident MRSA.  visician 's notes for lent 58 's, dated 7/24/18, came from hospital after the ction with MRSA and		Admission the admitting nurse plead Contact precautions set up outsing Resident#58 door, but did not observed physician sorder for the precaution Licensed Nurse initiated new bot tube feeding formula without proplabeling the bottles for Residents #1.  2. The procedure for implement	de of stain a tions and tiles of perly #25 and	
	7/26/2018, revealed	nurses ' notes, dated that Resident #58 continued precaution and antibiotic		acceptable plan of correction for specific deficiency cited.  a) It is the policy of Brian Center Yanceyville to ensure residents of Isolation Precautions have Physical orders for the precautions and winitiating new bottles of tube feed	er of on cian⊡s hen	
	room with contact iso personal protective e the door. The resider	r, Resident #58 was in the plation precaution sign and quipment (PPE) mounted to not indicated that he received the to his eye infection, and		formula licensed nurses should libottles. Licensed Nurse education provided by the Staff Developme Coordinator (SDC) completed by September 11, 2018 that resident Isolation Precautions are to have Physician sorders for the precaund when initiating new bottles of	abel the	
	#1 indicated that Resisolation precaution f MRSA. The nurse corevised or initial physisolation precaution.  On 8/8/18 at 1:45 PM Assistant of Director that Resident #58 cadiagnoses of MRSA icontact isolation precipility.	1, during an interview, Nurse sident #58 received contact or the eye infection with uld not provide the current, sician 's order for contact  1, during an interview, the of Nursing (ADON) indicated me from the hospital with in his eyes. He received caution. The ADON could not it's order for isolation		feeding formula licensed nurses label the bottles.  3. The monitoring procedure to that the plan of correction is effect that specific deficiencies cited recorrected and/or in compliance we regulatory requirements.  a) The SDC will perform a docuaudit of all residents on Isolation Precautions to validate Physiciar orders and observation audits of feeding formula bottles to validate labeling of bottle weekly for 4 we then 10 random care plans weekly) The SDC will report findings	should  ensure ctive and mains vith the umented  all tube e proper eks, and kly X 8.	

Facility ID: 923000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345265	B. WING		C 08/09/2018	
	ROVIDER OR SUPPLIER	В/ҮА		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 33,00,23 13	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 684	Director of Nursing (Dexpectation the nurse from physician to star precaution.  2. Resident #25 add the quarterly MDS as revealed severe impadiagnoses included dalzheimer's disease Review of Resident 25/30/18, revealed the feeding and nothing be provide adequate nutregimen, with no side interventions were to feedings and at least have dietitian to obseestimate needs quarter.	, during an interview, the DON) indicated her as should obtain the order thend the isolation  mitted on 9/21/17. Review of sessment, dated 5/16/18, irred cognition. Her ysphagia, stroke and . She received tube feeding.  5 's plan of care, dated resident received tube by mouth. The goal was to rition via enteral nutrition effects of tube feeding. The elevate head of bed during one hour after feeding, to rve caloric intake and	F 68-		r the an of ill be	
	remove per schedule Record review of the July-August 2018 rev received enteral feed it well. On 8/7/18 at 8:10 AM observation/interview tube feeding system v s gastric tube (surgica stomach) via working	nteral feed for nutrition and Nothing by mouth diet.  multiple nurses ' notes for ealed that Resident #25 ings every day and tolerated  , during the , resident was in bed. The was connected to resident ' ally inserted tube to the infusion pump. It was 1 L  1.5 Cal, with 780 ml of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345265	B. WING				O9/2018
	ROVIDER OR SUPPLIER	L		1	STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  (ANCEYVILLE, NC 27379	1 00/	09/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	s name, date or time.  On 8/7/18 at 10:10 Al Nurse Unit Manager i responsible for tube for Resident #25 last night nurse started new borrate of 100 ml per house labeled the bottle.  On 8/9/18 at 1:10 PM DON indicated that staign the tube feeding name, date and time.  3. Resident # 1 was 3/9/07 with the last rediagnoses which includisease, quadriplegiag gastrostomy status (trabdomen for feeding). Review of the physici revealed Glucerna 1.5 diabetic residents) at continuously via percegastrostomy tube.  Review of the compressessment dated 4/1 was assessed as cogadequate hearing and Review of Resident #4/18/18, revealed the feeding. The goals we nutrition via enteral near the start of the	M, during an interview, the ndicated that she was eeding administration for ht. On 8/6/18 at 7 PM, the title of Javity, 1.5 Cal on the ur. She could not recall if  , during an interview, the ne expected the nurses to formula with resident 's of infusion.  admission on 7/27/18 with ude cerebrovascular, dysphagia and ube placement in the nutrition).  an orders dated 7/27/18  Cal (supplement used for 65 milliliters (ml)/ hour (hr.) utaneous endoscopic  chensive annual MDS  17/18 revealed Resident #1 nitively impaired with	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345265	B. WING		08/09/2018	
	ROVIDER OR SUPPLIER	В/ҮА		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 684	Continued From pag	e 18	F 68	1		
	document/ report any tube placement and protocol, provide tub flushes as ordered.	during feedings, observe/ / signs of aspiration, check gastric residuals per facility e feeding formula/ water				
	Resident #1 was obsfeeding (TF) system gastric tube (surgical stomach) via working L (liter) bottle of Gluc formula that was har resident 's name, da	n on 8/6/18 at 10:45 AM, served lying in bed. The tube was connected to resident 's ly inserted tube to the ginfusion pump. An empty 1 serna 1.2 Cal nutrition ging, was not labeled with te or time. Observations also hanging that was not labeled e, date or time.				
	Resident # 1 was ob infusion pump workir to resident 's gastric An approximately ha	n on 8/6/18 at 3:32 PM, served lying in bed, the ng, and TF system connected tube via the infusion pump. If-empty flush bag was labeled with resident 's				
	# 1 indicated Reside Glucerna 1.5 Cal at 6 6 ml of flushes that w pump. She stated sh was labeled by the p she checked on the residuals and offered	on 8/8/18 at 10:00 AM, Nurse on # 1 was on continuous TF, 65 ml/ hour and 175ml every was infused by the infusion e does not recall if the bottle revious nurse. She stated resident 's TF site, gastric I flushes as ordered before edication administration, and bottle was labelled.				
	Manager indicated s	on 8/8/18 at 1:45 PM, Unit ne was unsure why the nurse formula bottle and flush bag				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345265	B. WING			1	C ( <b>09/2018</b>
	ROVIDER OR SUPPLIER	В/ҮА		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379		<u>, oo,</u>	00/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	bottle or new flush ba should label it with re- time of infusion.  During an interview o Director of Nursing st	when a new TF formula g was started, the nurse sident 's name, date and n 8/9/18 at 6:45 PM, the ated it was her expectation	F	684			
F 693 SS=D	name, date and time stated it was the resp	Restore Eating Skills	F	693			9/11/18
	both percutaneous er percutaneous endosc enteral fluids). Based	c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's ssment, the facility must					
	eat enough alone or venteral methods unlescondition demonstrate	ent who has been able to with assistance is not fed by ss the resident's clinical es that enteral feeding was d consented to by the					
	means receives the a services to restore, if and to prevent compli- including but not limit diarrhea, vomiting, de abnormalities, and na	ent who is fed by enteral ppropriate treatment and possible, oral eating skills ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic isal-pharyngeal ulcers.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(3) DATE SURVEY COMPLETED
		345265	B. WING _			C <b>08/09/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00,00,2010
				1086 MAIN STREET NORTH		
BRIAN CE	NTER HEALTH & REHA	B/YA		YANCEYVILLE, NC 27379		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 693	interview, the facility is order tube feedings residents reviewed for and Resident # 68). Findings included:  1.  Resident # 1 was adra 3/9/07. Resident #1' cerebrovascular disea and gastrostomy state abdomen for feeding.  Review of the compression of the comp	ns, record review and staff failed to follow the physician ' (TF) for 2 of 5 sampled r tube feeding (Resident #1)  mitted to the facility on s diagnoses included ase, quadriplegia, dysphagia us (tube placement in the nutrition).  The hensive annual Minimum assment dated 4/17/18 was assessed as with adequate hearing and dent was also assessed as the person assist with g (ADL). Resident# 1 was no swallowing disorder and g.  1 's plan of care, dated resident received tube are to provide adequate attrition regimen, with no side g. The interventions were to during feedings, observe/ signs of aspiration, check gastric residuals per facility a feeding formula/ water	F 6	Preparation and/or execution of Correction does not constitut admission by the provider of the facts alleged or the conclusions in the statement of deficiencies of correction is prepared becaurequired by the provision of the State Law. F693  1. The plan of correcting the state deficiency. The plan should addrocess that lead to the deficier a) Resident #1 and Resident currently receiving their tube fee physician sorder. It is alleged facility failed to administer Resiand Resident #68 tube feeding physician order. The process the deficiency is Licensed Nurse administer the tube feeding per physician sorder for Resident #1.  2. The procedure for implement acceptable plan of correction for specific deficiency cited. a) It is the policy of Brian Central Yanceyville to ensure residents receive tube feeding formula rethe physician order and when we bottles of tube feeding formula rethe physician order and when hew bottles of tube feeding formula rethe physician completed by September 11, 20 residents receive tube feeding freceive it per the physician or constitution of the physician or completed by September 11, 20 residents receive tube feeding freceive it per the physician or constitution of the physician or completed by September 11, 20 residents receive tube feeding freceive it per the physician or constitution of the physician or constitution of the provision of the fact of the provision of the provision of the fact of the provision of the provis	te e truth of se truth of se set forth. This plan are it is rederal 8 specific dress the ncy. #68 are eding per that the dents #1 per nat led to se did not se #68 and enting the or the se did not se #68 and enting the or the se in initiating mula e bottles. Fided by the (SDC) on 18 that formula order and	t t er g
	Resident # 1 was rea	dmitted on 7/27/18.		when initiating new bottles of tu formula licensed nurses should		-

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ISTRUCTION	` ′	SURVEY
		345265	B. WING _			1	C <b>/09/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/	03/2010
				1086 N	IAIN STREET NORTH		
BRIAN CI	ENTER HEALTH & REHA	B/YA			EYVILLE, NC 27379		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From page	e 21	F 6	693			
L 092	Review of the hospita 7/27/18 revealed Res discharge was Gluce per hour (ml/hr.) and cubic centimeters (cowere verified and sign 7/27/18.  Review of the physici revealed Glucerna 1. continuously via percegastrostomy (PEG) to hours flushes.  Review of nursing no 8/1/18 revealed residinterdisciplinary team related to weight loss #1 was tolerating TF loss was attributed to due to Urinary Tracticissues of PEG tube diste.  During an observation Resident #1 was obsinfusion pump was not (TF) system was contube (surgically insert working infusion pum of Glucerna 1.2 calor was hanging. It was name, date or time. Of flush bag hanging that resident 's name, date.)	al discharge summary dated sident #1 's TF order at rna 1.2 Cal at 65 milliliters free water flushes at 175 ) every 6 hours. Orders ned by the physician on  an orders dated 7/27/18 5 Cal at 65 ml/hr. utaneous endoscopic ube. 175 ml water every 6  tes from 6/1/18 through ent was reviewed by (IDT) in standard of care . Notes indicated Resident and flushes well. Weight frequent hospitalizations infection and due to some raining around the stoma  n on 8/6/18 at 10:45 AM, erved lying in bed and the ot running. The tube feeding nected to resident 's gastric red tube to the stomach) via p. An empty 1 L (liter) bottle ries per cc nutrition formula not labeled with resident 's observations also revealed a at was not labeled with		book 3. the state of the control of	The monitoring procedure to ensure at the plan of correction is effective a at specific deficiencies cited remains prected and/or in compliance with the gulatory requirements.  The SDC will perform a document observation audit of all residents who ceive tube feeding to validate tube eding is being administered per hysicians orders and all tube feeding rmula bottles to validate proper label bottle weekly for 4 weeks, and then indom observations weekly X 8.  The SDC will report findings of autonthly to the Quality Assurance enformance Improvement (QAPI) committee monthly X 3 for tracking an ending purposes with all follow up act etermined by the QAPI team.  Title of person responsible for inplementation of the acceptable POC.  The SDC will be responsible for the plementation of the acceptable plan or prection.  Dates when corrective action will be impleted. The corrective action dates ust be acceptable to the State.  September 11, 2018	nd e ed ing 10 dits d cion e of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345265	B. WING		C 08/09/2018
	ROVIDER OR SUPPLIER	B/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 00/00/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 693	every 6 hrs. Observar revealed 1 Liter (L) G "8/6/18 at 10 AM". A formula was remainir bag was half empty a time on it.  During an observatio Resident #1 was obs pump was not runnin was not connected to Observation also revealed and connected to the resire vealed the 1 L Glud was placed at the food During an observation Resident #1 was obs had not been connected was not started.  During an observation Resident #1 was observation also revealed the 1 L Glud was placed at the food During an observation Resident #1 was observation Resident #1 was observed. Interviewealed resident docactivities.  During an observation Resident #1 was observed. Interviewealed resident docactivities.	tion of the TF formula flucerna 1.2 Cal labeled pproximately 800 ml of ag in the bottle. The flush and had no label or date and an on 08/07/18 at 8:17 AM erved in bed. The infusion g. The tube feeding system or resident 's gastric tube. ealed a 1 L bottle of a placed on the side table.  In on 08/07/18 at 10:10 AM, ag in bed, the infusion pump tubing system was not dent. Observations also cerna 1.2 Cal formula bottle of the bed.  In on 8/7/18 at 11:20 AM, erved lying in bed and TF ted and the infusion pump  In and interview on 8/7/18 at 1 was observed in activity er chair, watching TV. No TF iew with the activity director es not receive TF during  In on 8/7/18 at 5:45 PM, erved in bed. TF infusion	F 69	3	
	Resident #1 was obs had not been connect was not started.  During an observatio 2:45 PM, Resident #1 room in a Geri recline was observed. Interv revealed resident doe activities.  During an observatio Resident #1 was obs pump indicated the formal resident formal resident was observed.	erved lying in bed and TF sted and the infusion pump  In and interview on 8/7/18 at If was observed in activity er chair, watching TV. No TF siew with the activity director les not receive TF during  In on 8/7/18 at 5:45 PM, erved in bed. TF infusion formula infusion rate was 60 ula Glucerna 1.5 Cal was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		345265	B. WING _			C 08/09/2018
	ROVIDER OR SUPPLIER	B/YA		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379		5576572010
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 693	Continued From page	e 23	F 6	93		
	Resident #1 was obs infusion pump indicated was 60 ml/ hr. Nutrition was hung and labeled.  During an interview of #1 (assigned to the rowas on Glucerna 1.5 received 175 ml of w. Nurse # 1 stated the tray and tube feeding before meals. Nurse physician 's orders for before meals. Nurse	on 8/8/18 at 10:00 AM, Nurse resident) stated Resident # 1 Cal at 65 ml/hr. and ater flushes every 6 hours. resident received a pleasure was stopped one hour was unable to find the or stopping the TF one hour				
	Review of nutrition as revealed Resident #1 (7.6% in 30 days) due Dietitian, in her nutriti recommended chang Glucerna 1.5 Cal (suresidents) at 80 ml/h	ssessment dated 8/8/18 I with significant weight loss e to hospital stay. The ion assessment, jing the enteral order to pplement used for diabetic ir. for 20 hrs. and increase cubic centimeters (cc) every				
	feeds of Glucerna 1.5 further stated she had 8/7/18 and had increasing for 20 hours to accompany for 20 hours to accompany for 20 hours to accompany for 20 hours. The Dietitian incompany for 20 hours accompany for the state of 20 hours. The base of the state of 20 hours accompany for the state of 20 hours. The state of 20 hours accompany for the state of 20 hours accompany for the state of 20 hours. The state of 20 hours accompany for the state of 20 hours accompany for the state of 20 hours. The state of 20 hours accompany for 20 ho	on 8/8/18 at 1:30 PM, lent # 1 was on continuous 5 Cal at 65 ml/ hour. She d reassessed the resident on ased the rate to 85 ml/hour nmodate time for resident 's dicated the TF was stopped og staff, hence the rate of r a shorter period of time i.e. lodate Resident # 1 's indicated she was unsure leped for a prolonged period				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		OMPLETED
		345265	B. WING _			C 08/09/2018
	ROVIDER OR SUPPLIER	B/YA	•	STREET ADDRESS, CITY, STATE, ZIP CODI 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379		36,66,2616
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 693	and she expected nuphysician's orders formula an interview of manager stated Resifeeding - Glucerna 1 stated the nurses we formula when bottle per physician orders system in place to do hung. She stated nuitime the bottle when replaced. She indica monitor the actual areach date and it was on all shift to check to formula bottle as need to be clarified.  On 08/09/18 at 6:34 Director of Nursing (lexpectation nursing staff formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding and label the TF form formula when empty staff were responsible as ordered with corresponding to the transfer of the trans	on 8/8/18 at 1:45 PM, Unit dent # 1 was on continuous .5 Cal at 65 ml/ hour. She are responsible to replace TF was empty and set the rate . She indicated there was no ocument when the bottle was reses should label, date and new TF formula bottle was ted there was no system to mount formula administered the responsibility of nurses he amount and replace the	F6	93		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345265	B. WING			C 08/09/2018
	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	ı	06/09/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 693	hearing, unclear speunderstood or under severely impaired of The resident require staff members for all (ADL). The active dhemiplegia, TBI, condysphagia, gastrostoquadriplegia.  A review of Resident 7/3/18 revealed an Arequired, communicatis physical and soc potential for fluid volat risk for nutritional  On 8/6/18 at 9:30 at Resident #68 who whead of the bed elev was present with a 3 nutritional suppleme was on hold and not A review of Resident dated 8/3/18 revealed tube via pump at 72 hour, run 6 am - 4 pumilliliters total.  On 8/6/18 at 12:45 pof Resident #68 and at 72 ccs per hour.  On 8/7/18 at 9:25 at who stated she turnefeeding off on 8/6/18 pass because she through the several	and the resident had adequate sech, and was rarely stands. The resident had a significant with no behaviors. It is activities of daily living stands are applied and the sech activities of daily living stands were aphasia, stracture of the left hand, omy, and functional at #68 's care plan dated and the second deficit and total care section deficit, dependent for sial needs, impaired cognition, tume deficit, tube feeding, and deficit.  In an observation was done of as lying in his bed with the stated. A tube feeding pump of full bottle of Jevity in that was dated. The pump	F 6	93		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345265	B. WING		08/09/2018
	ROVIDER OR SUPPLIER	В/ҮА		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	00,000,2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 693 F 695 SS=D	infusing from 6 am to Nurse #3 stated she on around noon when On 8/7/18 at 11:10 ar of Resident #68 and at 72 ccs per hour.  On 8/9/18 at 3:45 pm with the Director of Nexpected staff to folloorder.	the tube feeding was to be 4 pm at 72 ccs per hour. turned the tube feeding back in she realized her mistake.  In an observation was done his tube feeding was running an interview was conducted ursing who stated she with tube feeding physician stomy Care and Suctioning	F 69		9/11/18
	The facility must ensineeds respiratory car care and tracheal succare, consistent with practice, the compredicate plan, the resider and 483.65 of this sure This REQUIREMENT by:  Based on record reviand resident interview a physician order for failed to administer the for 3 of 5 sampled respiratory (Resident Findings included:  1.	nd tracheal suctioning.  ure that a resident who e, including tracheostomy etioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart.  is not met as evidenced few, observations, and staff ws, the facility failed to obtain oxygen administration and the correct oxygen liter flow		Preparation and/or execution of this F of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This prof correction is prepared because it is required by the provision of the Federa State Law. F695  1. The plan of correcting the specific deficiency. The plan should address the	of tth olan al &

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		345265	B. WING _		d	8/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
		14.5074		1086 MAIN STREET NORTH		
BRIAN CE	ENTER HEALTH & REF	IAB/YA		YANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	syncope and collap respiratory failure v congestive heart fa	nge 27 Imonary nodule, tachycardia, use, sepsis, pneumonia, vith hypoxia, anemia, ilure (CHF), chronic ary disease (COPD), and	F 6	process that lead to the defi a) Resident #26, Resident Resident #68 are currently r oxygen per physician □s ord alleged that the facility failed	#60 and eceiving er. It is	
	A review of Resider anticipated Minimur revealed the reside impaired with mem required extensive daily living (ADL) exactive diagnoses w COPD.  Resident #26 's ca goals and intervent ADL deficit, wishes	nt #26 's discharge with return m Data Set dated 7/1/18 ont was moderately cognitively ory deficit. The resident assistance for all activities of except meals were set up. The ere anemia, CKD stage 3, and re plan dated 8/6/18 revealed ions for cardiac complications, to return home, at risk for a, pneumonia, psychotropic		administer Residents #26, Rand Resident #68 oxygen porder. The process that led deficiency is Licensed Nurse obtain and administer the oxphysician sorder for Residand #68.  2. The procedure for imple acceptable plan of correction specific deficiency cited.  a) It is the policy of Brian oxyanceyville to ensure reside receive oxygen have a phys for the oxygen and receive in physician sorder. Licensed education provided by the S	Resident #60 er physician to the es did not eygen per ents #26, #60 ementing the in for the  Center of ents who ician s order t per the d Nurse	
	A review of the nurse revealed Resident and oxygen at 2 liters in saturation was 66-8 pulse was 88, respingeressure was 83/52 were called to transhospital.  Resident #26 returnand the diagnoses A review of the nurse	ses ' note dated 5/8/18 #26 was resting in bed with a progress. The oxygen 88%, temperature was 97.3, iratory rate was 16, and blood 1. Emergency services (911) sport the resident to the ned to the facility on 5/12/18 were CHF and pneumonia. ses ' note dated 5/25/18 int had oxygen via nasal		Development Coordinator (S completed by September 11 residents who receive oxyge physician sorder and receiphysician order.  3. The monitoring proceduthat the plan of correction is that specific deficiencies cite corrected and/or in compliar regulatory requirements.  a) The Assistant Director of N will perform a documented caudit of all residents who receipted to validate physician sorder validate oxygen is being adr	SDC) , 2018 that en have a live it per the lire to ensure effective and ed remains nce with the lof Nursing lursing (DON) lobservation loceive oxygen er and to	
		ses ' note dated 7/1/18		the physician s order week	ly for 4 weeks,	
	TEMPSIER THE REGIDE	IN WAS LE-SUMITION TO THE	1	I and then ill random observe	STILLING WADAIN	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED	
		345265	B. WING _				C <b>/09/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	1 00/	00/2010	
		20/4		1086 MAIN STREET NORTH				
BRIAN CE	NTER HEALTH & REHA	В/ҮА		YANCEYVILLE, NC 27379				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE	
F 695	care for self and requithoracentesis (removilung by needle aspirathospital today of the licentimeters removed to the back of the left resident was wobbly short of breath very e On 8/6/18 at 1:30 am Resident #26 who was and her oxygen concerts did not reveal On 8/6/18 at 10:30 ar of Resident #26 who cannula and her oxygen regulator was set to 20 On 8/8/18 at 2:05 pm resident and her oxygon oxygen concentrator liters.  On 8/8/18 at 2:05 pm with Resident #26 who was increased to 3 little better.  On 8/8/18 at 5:00 pm conducted of Resider concentrator which resiliters.	but very confused, unable to ired total nursing care. A al of fluid from around the action) was performed at the eft lung with 1500 cubic. There was slight swelling lower lobe (lung). The on her feet and had gotten asily.  an observation was done of as wearing a nasal cannula centrator regulator was set to an order for oxygen.  The action of the gen oxygen concentrator to the gen via nasal cannula regulator was set to 3.5  an interview was conducted to stated that her oxygen ers today and she is feeling an observation was done was to 3.5  an observation of the gen via nasal cannula regulator was set to 3.5	F 6	X 8. b) The ADON or DON will re of audits monthly to the Quality Performance Improvement (Committee monthly X 3 for tratrending purposes with all foll determined by the QAPI team 4. Title of person responsibility implementing the acceptable a) The DON will be responsimplementation of the accepta correction.  5. Dates when corrective accompleted. The corrective accompleted. The corrective accompleted. The state and September 11, 2018	ity Assurant API) acking and ow up act on. le for POC. sible for the able plant of the cition will be ton dates	nce  d ion  le of		
		ed on 8/8/18 and back dated xygen 2 liters by nasal						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED	
<b>345265</b> B. WING	C 08/09/2018	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD PREFIX (EACH CORRECTIVE A	BE COMPLETION	
Continued From page 29 cannula as needed for shortness of breath.  Resident #26 's vital sign log for oxygen saturation revealed documentation of oxygen administration daily from 4/28/18 to 8/8/18. The oxygen flow rate was not documented.  On 8/9/18 at 10:00 am an interview was conducted with Resident #26 who stated she increased the oxygen flow rate on the oxygen concentrator yesterday because she had increased shortness of breath. The resident was comfortable with 2 liters of oxygen today. The resident stated she had not notified the staff and would let the nurse know if she was short of breath.  On 8/9/18 at 10:00 am an observation of Resident #26 was done, and the oxygen concentrator was set to 2 liters nasal cannula. The resident was relaxed and not short of breath.  On 8/9/18 at 10:10 am an interview was conducted with Nurse #6 who stated that she was not aware that Resident #26 had changed her oxygen concentrator flow rate yesterday while she was on duty. Nurse #6 stated that she checked the oxygen concentrator for flow rate as part of her assessment and had not observed 3 liters oxygen flow for her shifts.  On 8/9/18 at 3:45 pm an interview was conducted with the Director of Nursing who stated she expected staff to obtain an order for oxygen and monitor the oxygen flow rate and document.		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345265	B. WING_			C <b>8/09/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 0	0/03/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	dementia without be repeated falls, fractuanxiety, asthma, and weakness.  A review of Residen Data Set (MDS) ass revealed the resider speech and was und Her cognition was unsecondary to memono behaviors. The rassistance of 2 staff all other activities of meals were set up. non-Alzheimer's deschizophrenia, and a oxygen dependent.  A review of Residen 7/8/18 revealed goal emotional and intelled behavior and commic cognition, seizure di respiratory complicated A review of Residen revealed oxygen saft dated from 2/28/18 to documented that the oxygen almost every was not documented.	ity diagnoses were epilepsy, havioral disturbance, are of ribs and nasal bones, a generalized muscle  It #60 's quarterly Minimum dessment dated 6/28/18 at had adequate hearing, clear derstood and understands. Inable to be assessed by deficit. The resident had desident required extensive for transfer and one staff for daily living (ADL) except. The active diagnoses were ementia, seizure disorder, asthma. The resident was at #60 's care plan dated as and interventions for ectual needs, ADL deficit, unication deficit, impaired sorder, and at risk for tions.  It #60 's record of vital sign urration by pulse oximetry on the 8/8/18 was a resident was administered of day and the oxygen liter flow	F 6	· · · · · · · · · · · · · · · · · · ·		
	cannula present in h concentrator flowing	heel chair with a nasal er nares and an oxygen at 3 liters. The resident was f and was confused. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345265	B. WING		C 08/09/2018
	ROVIDER OR SUPPLIER	B/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 30/06/2010
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 695	the bed and not withir resident was no obset.  On 8/6/18 at 9:45 am orders were reviewed administration could.  On 8/7/18 at 11:30 at observed to be sitting nasal cannula in her concentrator flowing resident 's record refor oxygen or nurses administration or the.  On 8/7/18 at 4:00 pm to be sitting in her who cannula in her nares flowing at 3.5 liters. record revealed there nurses 'notes for ox flow rate.  On 8/8/18 a physicial revealed oxygen tubic infection control and cannula as needed for (clarification effective).  On 8/8/18 at 11:30 at conducted with the All while looking at the median at the median and cannula was were selected.	was on the opposite side of in the resident 's reach. The erved to be short of breath.  Resident #60 's physician d and an order for oxygen not be found.  Resident #60 was g in her wheel chair with a nares and an oxygen at 3.5 liters. Review of the wealed there was no order 'notes for oxygen flow rate.  Resident #60 was observed neel chair with a nasal and an oxygen concentrator A review of the resident 's e was no order for oxygen or ygen administration or the  n order dated 8/8/18 ng change every Monday for for oxygen 2 liters via nasal or shortness of breath e 9/28/17 date of admission).	F 69	95	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	COMPLETED	
		345265	B. WING		C 08/09/2018	
	PROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	1 00/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 695	3.  Resident #68 was a diagnoses of hypert brain injury (TBI).  Resident #68 ' s quadated 7/2/18 reveale hearing, unclear spounderstood or understood or understaff members for a active diagnoses was aphasia, hemiplegia hand, dysphagia, and A review of Resident 7/3/18 revealed and required, communication his physical and soo potential for fluid vorotential for pain.  A review of the nurs 3/22/18 revealed the oxygen 3 liters nasat through 6/25/18 dooresident was on 3 liters nasat through 6/25/18 dooresident was on 3 liters after 6/25/18 administration.  On 8/6/18 at 9:30 at Resident #68 who wilters of oxygen by cannula that was lying A review of Resident	dmitted on 4/22/98 with the ension, quadriplegia, and total arterly Minimum Data Set ed the resident had adequate eech, and was rarely restands. The resident had a cognition with no behaviors. Ed extensive assistance of two I activities of ADLs. The ere hypertension, pneumonia, I, TBI, contracture of left and functional quadriplegia.  It #68 's care plan dated ADL deficit and total care ation deficit, dependent for sial needs, impaired cognition, lume deficit, pneumonia, and les ' notes dated back to e resident was admitted with all cannula. Nurses ' notes sumented periodically that the ers nasal cannula. Nurses ' did not mention oxygen  In an observation was done of vas lying in his bed with 2.5 concentrator flowing via nasal	F 699	5		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345265	B. WING				09/2018
	ROVIDER OR SUPPLIER	В/ҮА		10	TREET ADDRESS, CITY, STATE, ZIP CODE 086 MAIN STREET NORTH 'ANCEYVILLE, NC 27379	1 001	00/2010
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	of Resident #68 who liters of oxygen by co was wearing his nasa. On 8/7/18 at 11:10 ar of Resident #68 who liters of oxygen by co was wearing his nasa. On 8/8/18 at 9:30 am Resident #68 who wa liters of oxygen by co cannula.  On 8/8/18 at 2:00 pm Resident #68 who wa liters of oxygen by co cannula.  On 8/8/18 at 2:00 pm Resident #68 who wa liters of oxygen by co cannula.  On 8/7/18 a review of oxygen saturation revreceiving oxygen from flow rate was not doc.  On 8/7/18 at 9:25 am with Nurse #3 who stasupposed to be on 2 loxygen concentrator Nurse #3 stated she I liters after viewing the level. Nurse #3 state physician order for oxygen concentror oxygen concentror oxygen concentror oxygen concentror oxygen concentrator	n an observation was done was lying in his bed with 2.5 incentrator flowing and he il cannula.  In an observation was done was lying in his bed with 2.5 incentrator flowing and he il cannula.  In an observation was done of its lying in his bed with 2.5 incentrator flowing via nasal  In an observation was done of its lying in his bed with 2.5 incentrator flowing via nasal  In an observation was done of its lying in his bed with 2 incentrator flowing via nasal  In Resident #68 's vital sign realed the resident was in 3/22/18 to 8/7/18 and the umented.  In an interview was conducted ated Resident #68 was liters nasal cannula and the was dialed to 2.5 liters. owered the oxygen to 2 in regulator at horizontal, eyed it Resident #68 had no tygen, there was a facility	F	695			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED		
		345265	B. WING			C
	ROVIDER OR SUPPLIER	L	2	STREET ADDRESS, CITY, STATE, ZIP CO 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379		08/09/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 755 SS=D	written by the physician written by the physician on 8/8/18 a physician liters of oxygen via nate effective 7/29/18.  On 8/9/18 at 3:45 pm with the Director of Niexpected staff to obtain monitor the oxygen floor control of the expected staff to obtain monitor the oxygen floor control of the expected staff to obtain monitor the oxygen floor control of the expected staff to obtain the expecte	an order was created for 2 asal cannula and back dated an interview was conducted ursing who stated she in an order for oxygen and ow rate and document. Sedures/Pharmacist/Records (1)-(3)  ervices ide routine and emergency to its residents, or obtainment described in ity may permit unlicensed for the general supervision of es. A facility must provide the ses (including procedures ate acquiring, receiving, nistering of all drugs and the needs of each resident.  onsultation. The facility on the services of a licensed es consultation on all on of pharmacy services in		755		9/11/18
	3400.40(n)(∠) Establis	shes a system of records of				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345265	B. WING		C 08/09/2018
	ROVIDER OR SUPPLIER	AB/YA	STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379		00/03/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 755	sufficient detail to e reconciliation; and \$483.45(b)(3) Dete order and that an a is maintained and p	ion of all controlled drugs in	F 75	55	
	by: Based on observat record reviews, the unused controlled s disposition (the pro- destroying unused was discharged wit	ions, staff interviews, and facility failed to identify ubstance medications for cess of returning and/or medications) after a resident in his return not anticipated for y re-admitted residents		Preparation and/or execution of this P of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This p of correction is prepared because it is required by the provision of the Federa State Law.	of th lan
	facility on 6/1/18 wi which included a hi- cancer.	oreviously admitted to the the the diagnoses story of throat and neck		<ol> <li>The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency.</li> <li>a) Resident #45 is receiving medicate per physician order. Resident #45 was discharged from the center, return not anticipated and the resident □s narcotic</li> </ol>	ne ion s cs
	revealed his medical in part: 2 milligrams opioid pain reliever mouth every 4 hour and 0.5 mg lorazep medication) to be g for anxiety (ordered The resident was d 7/13/18 with his return Resident #45 was r 7/24/18 from the hour part of the revealed his medical part of the resident was d 7/13/18 with his return Resident #45 was r 7/24/18 from the hour part of the revealed his medical part of the resident was d 7/13/18 with his return revealed his medical part of the resident was d 7/13/18 from the hour part of the revealed his medical part of the revealed h	iven by mouth two times a day		were not returned to the pharmacy. It i alleged that the facility failed to identify controlled drugs for disposition after Resident #45 discharged from the faci The process that led to the deficiency Licensed Nurses did not return Reside #45 narcotics to the pharmacy when Resident #45 discharged home return anticipated.  2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited.  a) It is the policy of Brian Center of Yanceyville to identify controlled drugs	lity. is int not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345265	B. WING			C 98/ <b>09/2018</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	0.00.20.0	
				1086 MAIN STREET NORTH			
BRIAN CE	BRIAN CENTER HEALTH & REHAB/YA			YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	e 36	F 75	55			
	projection of the seconeck).  A review of Resident	and cervical vertebra in the #45 's medical record		disposition after discharged fro facility or discontinuance of con medication. Licensed Nurse ed staff and agency Licensed Nur	ntrolled lucation to ses		
	the facility included th	ions upon re-admission to ne following, in part: 2		provided by the Staff Developer Coordinator (SDC) completed	by		
		omorphone (an opioid pain		September 11, 2018 that contr	-		
	, .	as one tablet by mouth every		are to be sent to the pharmacy			
		ered 7/24/18); and 0.5 mg exiety medication) to be given		disposition after a resident is d from the facility or discontinuar	-		
		a day for anxiety (ordered		controlled medication. Controll			
	7/24/18).	day for afficity (ordered		Medications will be sent to the			
	, .			as indicated, with discontinuan	•		
	A review of the reside	ent 's Controlled Medication		medication or discharge of the			
		declining inventory log for		return not anticipated within 72			
	controlled substance			the Unit Coordinators, Unit Ma	-		
	conducted. These re	cords included:		Assistant Director of Nursing o			
	30 tablets of 2 mg h	nydromorphone were		of Nursing.			
	dispensed on 7/8/18	by the pharmacy for		b) During their classroom ori	entation,		
	Resident #45. The C	Controlled Medication		newly hired Licensed Nurse ed	lucation to		
	Utilization Record rev	ealed that on the date of the		staff and agency Licensed Nur	ses will be		
	resident 's discharge	e from the facility (7/13/18), 3		provided to include controlled	drugs are to		
		morphone were remaining in		be sent to the pharmacy for dis			
	-	eclining inventory log showed		after a resident is discharged f			
		blets were resumed for		facility or discontinuance of co			
		is readmission to the facility		medication. Controlled Medica			
	on 7/24/18.			be sent to the pharmacy, as in			
		lorazepam were dispensed		with discontinuance of medicat			
		rmacy for Resident #45. The		discharge of the resident return			
		n Utilization Record revealed		anticipated within 72 hours by			
		e resident 's discharge from		Coordinators, Unit Managers,			
	the facility (7/13/18),	aining in the inventory. The		Director of Nursing or Director 3. The monitoring procedure			
	-	ig showed use of these same		that the plan of correction is ef			
	_	d for Resident #45 upon his		that specific deficiencies cited			
	readmission to the fa			corrected and/or in compliance			
	readmission to the la	Onity Off 1/2-7/10.		regulatory requirements.	, with the		
	An interview was con	ducted 8/9/18 at 7:25 AM		a) The Assistant Director of N	Jursina		
		rector of Nursing (DON).		(ADON) or the Director of Nurs	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345265	B. WING _			C 08/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		00/09/2010	
				1086 MAIN STREET NORTH			
BRIAN CE	NTER HEALTH & RE	нав/үа		YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	of the concerns recontrolled substan admission (with reheld in the facility that was discharged will upon inquiry, the I controlled substanthe facility after a return not anticipal (controlled substansupposed to be redays of a resident "We've had so mustaff) help."  A telephone intervice 3:00 PM with the fultransupposed to be redays of a resident "We've had so mustaff) help."  A telephone intervice 3:00 PM with the fultransupposed to be redays of a resident "we've had so mustaff) help."	w, the DON was made aware garding Resident #45's ce medications from a previous turn not anticipate) having been for 10 days after the resident th his return not anticipated. DON was asked how long ce medications were kept in resident was discharged with a ted. The DON stated narcotics nee medications) were turned to the pharmacy within 3 is discharge. The DON stated, ch agency (temporary nursing liew was conducted on 8/9/18 at accility 's consultant pharmacist. Charmacist was asked what he accility to do with controlled tions remaining after a resident led with a return not sharmacist reported he facility send the controlled tions back to pharmacy for a count could be verified and the loyed. He reported the does not be sent to the pharmacy, "the	F 7		poservation is and ats are eturn not in 10 random alidate pharmacy ance of e resident eport findings at Assurance QAPI) acking and low up action in. The pool of the able plan of ction will be tion dates		
	the (medication) ca When the situation medications were stated, "That's a ca than would want."  A follow-up intervied 3:09 PM with the E facility 's Administ	would like to get them out of art due to accountability." In for Resident #45 's discussed, the pharmacist concern and a longer time frame where was conducted on 8/9/18 at DON in the presence of the rator. During the interview, the there was a facility policy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC' IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 t. BOILEST			С	
		345265	B. WING			08/	09/2018
	ROVIDER OR SUPPLIER  NTER HEALTH & REHAI	В/ҮА		10	TREET ADDRESS, CITY, STATE, ZIP CODE 086 MAIN STREET NORTH ANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 759 SS=D	back to the pharmacy resident's discharge was not a facility policissue, but the guidelir return these medicatin 72 hours of a resident Free of Medication Error CFR(s): 483.45(f)(1)  §483.45(f) Medication The facility must ensure facility f	ne frame by which medications should be sent of or disposition after a and the control of the polymer of the polymer of the pharmacy within the she gave her staff was to consider the pharmacy within the she she gave her staff was to consider the pharmacy within the she she gave her staff was to consider the pharmacy within the she she gave her staff was to consider the pharmacy within the she she gave her staff was to consider the pharmacy within the she gave her staff was to consider the pharmacy within the she gave her staff was to consider the she gave her staff was to consider the pharmacy within the she gave her staff was to consider the she gave her staff was to consider the pharmacy within the she gave her staff was to consider the she gave h		755	Preparation and/or execution of this Pl of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set fort in the statement of deficiencies. This pl of correction is prepared because it is required by the provision of the Federa State Law. F759  1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) It is alleged that Licensed Nurses on 8/9/18 while administering medication to Residents #17 and #24 respectively. The process that led to the deficiency is the Licensed Nurse is non-compliance with physician is orders for medication and time of administration.	ef th lan l & e #3 ons	9/11/18
	A review of Resident	#17 ' s Physician Order			The procedure for implementing the content of the procedure for implementing the content of	ie	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345265	B. WING		C		
NAME OF DE	ROVIDER OR SUPPLIER	0.40200		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	8/09/2018	
NAME OF F	NOVIDER OR SUFFLIER						
BRIAN CE	NTER HEALTH & REHA	B/YA		1086 MAIN STREET NORTH			
				YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 759	Continued From page	e 39	F 75	59			
F 759	Summary Report incling calcium to be give gastrostomy tube one.  An interview was contained and with Nurse #3. Under the resident #4 Administration Recommanufacturer is labeled combination calcium/ the resident. The nurordered and indicated same as the combination calcium/ administered to Resident hall medication casupplement (in the dophysician) was not streported she would ecalcium supplement or resident is physician product carried by the appropriate alternative.  An interview was contained with the facility is Dir During the interview, expectation was for the medications without the medications according 2) On 8/9/18 at 8:57 as she prepared and	en as one tablet via the time a day.  Iducted on 8/9/18 at 10:45 Ipon request, the nurse 17 's Medication Id (MAR) and the Iling on the stock bottle of the Ivitamin D tablets given to Irse confirmed the medication Id by the MAR was not the Interest of the cart. The nurse Interest of the cart. The nurse Interest of the cart or call the Ito see if another stock Ite facility would be an Irse.  Iducted on 8/9/18 at 3:09 PM Irsector of Nursing (DON). Ithe DON reported her Irbe the nursing staff to deliver the Irbe to the physician's orders.  AM, Nurse #7 was observed Iducted administered medications to	F 75	acceptable plan of correction for specific deficiency cited.  a) It is the policy of Brian Cen Yanceyville to administer medic physician sorders. Licensed Neducation provided by the Staff Development Coordinator (SDC completed by September 11, 20 physician sorders are to be for when administering medication as the Rights of Medication Admincluding the right resident at the time with the right medication in dose using the right route.  b) Newly hired Licensed Nursing Medication Aides will be educated their classroom orientation that physician sorders are to be for when administering medication as the Rights of Medication Admincluding the right resident at the time with the right medication in dose using the right route.  3. The monitoring procedure that the plan of correction is effect that specific deficiencies cited in corrected and/or in compliance regulatory requirements.  a) The Director of Nursing (Deassistant Director of Nursing, Umanagers, Unit Coordinators and perform fifteen random documents.	atter of cations per Nurse  C)  O18 that ollowed sas well ministration are right attended during of the right attended to ensure ective and emains with the ON), Unit and SDC will ented		
	included 25 milligram one tablet by mouth. entered for the med a Upon entering the roo made of the resident	dministered medications as (mg) quetiapine given as Resident #24 's room was administration at 9:09 AM. bm, an observation was lying in her bed with her already eaten) placed on her		observations of Licensed Nurse Medication Aides during Medica Administration Pass weekly for include monitoring of medicatio administered before meals as and then 10 random observation include monitoring of medication	ation 4 weeks to ns ordered, ns to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED			
		345265	B. WING	B. WING		C 08/09/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	IP CODE	00/09/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 759	bedside tray table. The indicated she had compatty, cream gravy, a and a House Shake (inutritional supplement of the interview of Resident Summary Report inclumilligrams (mg) quetiatione time daily before.  An interview was conswith Nurse #7. During made in regards to the quetiapine to be given the nurse confirmed to give the medication indicated she was filling called out and had state than it was usually stated and interview was conswith the facility. So During the interview, expectation was for the medications without emedications according Label/Store Drugs and CFR(s): 483.45(g)(h)(s) §483.45(g) Labeling of Drugs and biologicals labeled in accordance.	the resident 's meal ticket assumed pureed sausage pureed waffle with syrup, a high calorie, high protein tt).  #24 's Physician Order uded a current order 25 apine to be given by mouth breakfast.  ducted 8/9/18 at 10:40 AM g the interview, inquiry was e physician order for a before the breakfast meal. the physician 's order was a before breakfast, but ang in for a nurse who had carted medication pass later carted.  ducted on 8/9/18 at 3:09 PM ector of Nursing (DON). the DON reported her are nursing staff to deliver the errors and administer the g to the physician's orders. d Biologicals (1)(2)  of Drugs and Biologicals as used in the facility must be event of the process of the physician's ordered.	F 7	administered before meaweekly X 8 to validate or physicians orders. b) The DON will report monthly to the Quality A Performance Improveme Committee monthly X 3 trending purposes to assustained with all follow determined by the QAPI 4. Title of person respimplementing the accepta) The DON will be resimplementation of the accorrection. 5. Dates when correct completed. The correction must be acceptable to that a September 11, 2018	t findings of audits ssurance ent (QAPI) for tracking and sure compliance is up action team. onsible for table POC. sponsible for the ecceptable plan of tive action will be we action dates ne State.	9/11/18	
SS=E	§483.45(g) Labeling of Drugs and biologicals	of Drugs and Biologicals a used in the facility must be with currently accepted s, and include the y and cautionary					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
	<b>345265</b> B. WING				C 08/09/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379	08/09/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 761	§483.45(h)(1) In according Federal laws, the factoriologicals in locked temperature controls personnel to have according for the Comprehensive It Control Act of 1976 at abuse, except when package drug distribution quantity stored is mirror be readily detected. This REQUIREMENT by:  Based on observation facility failed to discastored in 3 of 5 medimed cart, lower 400 med cart) and in 2 of (100/200/300/400 Hamed room).  The findings included 1) An observation of medication cart was AM. The observation bag containing 15 - smilligram (mg) / 1 mil antipsychotic medication cart. The discast of the control	ordance with State and ility must store all drugs and compartments under proper, and permit only authorized cess to the keys.  cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can  T is not met as evidenced ons and staff interviews, the red expired medications cation carts (100/300 Hall Hall med cart, upper 600 Hall 2 medication rooms all med room and 600 Hall deconducted on 8/7/18 at 8:58 in revealed a brown plastic single dose vials of 5 lilliter (ml) haloperidol (an tion) dispensed from the	F 76	Preparation and/or execution of this P of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set for in the statement of deficiencies. This p of correction is prepared because it is required by the provision of the Federa State Law. F761  1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency.  a) It is alleged that the facility failed the discard expired medication from 3 of 5 medication carts and 2 of 2 medication rooms. The process that led to the deficiency is Licensed Nurses did not review expiration dates on medication the medication carts and medication rooms.	of th lan al & e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		<b>345265</b> B.				C 08/09/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00/00/2010	
				1086 MAIN STREET NORTH			
BRIAN CE	NTER HEALTH & REHA	B/YA		YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		
F 761	with Nurse #7. Durin haloperidol were inspected take it (the haloperidol pharmacy."  An interview was conwith the facility 's Dir During the interview, expectation was for tomedications to be suland not expired.  2) An observation of medication cart was and not expired.  2) An observation of medication cart was and not expired.  Coated bisacodyl tabe on the medication cart stock medications. Tower action in the medication cart was and not expiration date stamp 2018.  An interview was conwith Medication Aide was the nursing staff Upper 600 Hall medication was the stock beinspected. Med Aide medication was expired interview, the stock beinspected. Med Aide medication was expired to the facility 's Dir During the interview, expectation was for the state of the stat	aducted on 8/7/18 at 9:05 AM ag the interview, the vials of pected. Nurse #7 confirmed d. Nurse #7 stated, "I'll ol) off and sent to the aducted on 8/9/18 at 3:09 PM rector of Nursing (DON). The DON reported her the nurses to evaluate the re they were properly dated the Upper 600 Hall conducted on 8/7/18 at 8:58 in revealed an opened stock of milligrams (mg) Enteric elets (a laxative) was stored in a drawer with the other the manufacturer's ped on the bottle was May aducted on 8/7/18 at 9:00 AM (Med Aide) #1. Med Aide #1 member assigned to the cation cart. During the sottle of bisacodyl tablets was #1 confirmed the	F 7	2. The procedure for im acceptable plan of correct specific deficiency cited.  a) It is the policy of Briat Yanceyville to discard explicensed Nurse education Staff Development Coord completed by September expired medications are than and not stored in medicate medication rooms.  b) During their classroomewly hired licensed nurse educated that expired medicated that plan of correction that specific deficiencies corrected and/or in compiregulatory requirements.  a) Expired medication in medication cart and medidiscarded by the Unit Managers (Director of Nursing (Dondocumented observation medication carts and medication car	an Center of pired medication provided by the linator (SDC) of 11, 2018 that to be discarded tion carts or a morientation, see will be edications are the red in medication carts are the medication room who magers (UM), sing (ADON) of DON) per facility (UM), Assistant (N) or the control will perform a madit of all dication rooms idate there are in the medication rooms, ervations week the expired	the date on the date of the da	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345265	B. WING			C <b>08/09/2018</b>	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	·	00/03/2010	
			1086 MAIN STREET NORTH			
BRIAN CENTER HEALTH & RE	HAB/YA		YANCEYVILLE, NC 27379			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
medication cart way AM. The observation tablets (10) medication cart in medications. The date stamped on the date stamped on the date stamped on the date stamped to the Louring the interview was inspected. Not medication was expected and interview was inspected. Not medication was expected and interview was formedication was formedications to be and not expired.  4) An observation room was conducted observation reveat of 81 milligrams (in tablets (containing cabinet shelf with manufacturer is expected was January.  An interview was of with Nurse #8. Due bottle of aspirin was with Nurse #8. Due bottle of aspirin was apprinted to the date of aspirin was with state of aspirin was with state of aspirin was apprinted to the date of aspirin was was apprinted to the date of aspirin was apprinted to the date of a spirin was apprinted to the date of a spirin was apprinted to the date of a spirinted to the date of	of the Lower 400 Hall as conducted on 8/7/18 at 8:25 tion revealed an opened stock rams (mg) Enteric Coated 0 count) was stored on the a drawer with the other stock manufacturer 's expiration the bottle was June 2018.  conducted on 8/7/18 at 8:30 AM arse #3 was the hall nurse over 400 Hall medication cart. w, the stock bottle of aspirin turse #3 confirmed the spired and reported the stock bould need to be discarded.  conducted on 8/9/18 at 3:09 PM Director of Nursing (DON). w, the DON reported her or the nurses to evaluate the sure they were properly dated  of the 600 Hall medication ted on 8/8/18 at 7:55 AM. The led one unopened stock bottle mg) Enteric Coated aspirin 120 tablets) was stored on the other stock medications. The expiration date stamped on the	F 7		responsible ded one to one ADON.  N will report to the Quality provement X 3 for uses to assure going with all by the QAPI will be for the POC.  Insible for the ptable plan of action will be action dates		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED		
		345265	B. WING			C 08/09/2018	
	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	with the 2nd shift nu 600 Hall. The nurse of medications had l 600 Hall medication earlier in the day. Unurse reported these available for use on An interview was co with the facility 's D During the interview expectation was for medications to be stand not expired.  5) An observation of cart was conducted observation revealer insulin was stored of insulin vial was laber from the pharmacy of opened on 5/24/18. The vial by the pharmaceded to be discard. According to the propunctured (in use), I under refrigeration of within 28 days.  An interview was co with Nurse #1. Nurse assigned to the 100 During the interview.	nducted on 8/8/18 at 4:13 PM rse assigned to work on the reported a few stock bottles been previously stored in the room, but they were removed p until this date (8/8/18), the e stock meds had been	F 76	51			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345265	B. WING		08/09/2018	
	ROVIDER OR SUPPLIER	AB/YA		STREET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	33/00/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 761	with the facility 's E During the interview expectation was for medications to be sand not expired.  6) Accompanied by Nurse (RN), an obs 8/8/18 at 8:05 AM of medication room. To opened bottle of 25 vancomycin (an and compounded and dot 7/23/18 was stored room refrigerator. Awas written on the E pharmacy label planindicated the expired 7/30/18.  An interview was convicted with the corporate FRN confirmed the wand needed to be recommerfigerator.  An interview was convicted with the facility 's ED During the interview expectation was for	onducted on 8/9/18 at 3:09 PM birector of Nursing (DON).  v, the DON reported her the nurses to evaluate the ure they were properly dated  the corporate Registered ervation was conducted on of the 100/200/300/400 Hall The observation revealed one milligrams/milliliter	F 761			
	Nurse (RN), an obs 8/8/18 at 8:05 AM of medication room.	the corporate Registered ervation was conducted on of the 100/200/300/400 Hall The observation revealed 4 se vials (MDV) of influenza				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 501251				
		345265	B. WING			08/0	09/2018
	ROVIDER OR SUPPLIER	B/YA		STREET ADDRESS, CITY, STATE, ZIP CO 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 761	had an expiration dat multi-dose vial (MDV) stored in the refrigera 6/30/18 and was date. An interview was conwith the corporate RNRN confirmed the 5 vand needed to be represented by an interview was conwith the facility 's Dir During the interview, expectation was for the medications to be surand not expired. Infection Prevention 8 CFR(s): 483.80(a)(1) §483.80 Infection Conthe facility must estainfection prevention a designed to provide a comfortable environmed evelopment and transitional conformations. See Section 19 program. The facility must estation of the facility must estation for the facility must estation.	medication room refrigerator e of 6/30/18. One opened, of influenza vaccine also tor had an expiration date of ed as opened on 11/21/17.  ducted on 8/8/18 at 8:07 AM I. During the interview, the ials of Afluria were expired moved from the medication  ducted on 8/9/18 at 3:09 PM ector of Nursing (DON). the DON reported her ne nurses to evaluate the re they were properly dated  & Control (2)(4)(e)(f)  Introl blish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable		761			9/11/18
	reporting, investigating	ving elements: em for preventing, identifying, g, and controlling infections seases for all residents,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		345265	B. WING		08/09/2018		
	ROVIDER OR SUPPLIER	B/YA		STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 880	providing services un arrangement based up conducted according accepted national states \$483.80(a)(2) Written procedures for the procedure for the	tors, and other individuals ader a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and ogram, which must include, designed to identify to be diseases or a can spread to other or; Im possible incidents of the original possible incidents of the insert spread of infections; to lation should be used for a suit not limited to: attion of the isolation, infectious agent or organism that the isolation should be the ble for the resident under the sunder which the facility the es with a communicable kin lesions from direct to or their food, if direct the disease; and a procedures to be followed rect resident contact.	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345265	B. WING		C 08/09/2018		
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/YA				STREET ADDRESS, CITY, STATE, ZIP CODE  1086 MAIN STREET NORTH  YANCEYVILLE, NC 27379			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 880	REGULATORY OR LSC IDENTIFYING INFORMATION)  880 Continued From page 48 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.  §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to perform hand hygiene after a nurse handled an intravenous bag and its tubing after use on a resident, and before she handled medications during medication pass for 1 of 3 observations conducted for infection control.  Findings included:  On 8/7/18 at 9:05 am an observation was conducted of Nurse #3 who carried a completed bag of intravenous medication and its tubing from Resident #101 in her hand, walked down the hall to the medication cart, and discarded the contents in the medication cart garbage bag. Nurse #3 touched her computer, used her key to unlock the cart, and obtained medication cup without washing her hands. Nurse #3 used hand sanitizer before entering the resident's room to		F 880	Preparation and/or execution of this F of Correction does not constitute admission by the provider of the truth facts alleged or the conclusions set fo in the statement of deficiencies. This profession of correction is prepared because it is required by the provision of the Federa State Law. F880  1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency.  a) It is alleged that Licensed Nurse a failed to wash her hands after handling intravenous bag and its tubing after us on a resident, and before she handled medications. The process that led to the deficiency is the Licensed Nurse so non-compliance with infection control related to hand washing did not wash	Plan  of rth blan  al & che #3 g an se he		
	with Nurse #3 who si #101 's completed ir medication bag and t cart garbage bag. N remember not washi	ation.  an interview was conducted ated she discarded Resident atravenous (IV) antibiotic ability and the medication are #3 stated she did not a her hands after discarding cation bag and tubing before		hands after handling an intravenous b and its tubing after use on a resident, before she handled medications.  2. The procedure for implementing t acceptable plan of correction for the specific deficiency cited.  a) It is the policy of Brian Center of Yanceyville to perform hand washing when indicated by Infection Control	and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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		345265	B. WING _			08/09/2018		
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
DRIAN CENTER HEALTH & REHARINA					1086 MAIN STREET NORTH			
BRIAN CENTER HEALTH & REHAB/YA					YANCEYVILLE, NC 27379			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 880	Continued From page 49 continuing on with medication pass. Nurse #3 stated she thought she had washed her hands after discarding the IV bag and tubing and usually washed her hands between residents.  8/9/18 at 9:45 am an interview was conducted with the Infection Control Nurse (ICN) who stated all staff received infection prevention and control training upon hire and annually. The ICN also stated that there is an infection prevention policy that staff was expected to follow.  On 8/9/18 at 3:45 pm an interview was conducted with the facility 's Director of Nursing who stated she expected staff to follow the facility 's infection control standards.		FE		Practices. Licensed Nurse education provided by the Staff Development Coordinator (SDC) completed by September 11, 2018 that hand washing should be performed when hands are potentially contaminated from discontinuing intravascular lines and bay or handling intravascular lines or bags.  3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.  a) The SDC will perform a documente hand washing observation audit of Licensed Nurses during Medication			
					Administration Pass weekly for 4 week and then 10 random observations week X 8 to validate compliance with Infection Control Practices.  The SDC will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up act determined by the QAPI team.  4. Title of person for implementing the POC.  a) The DON will be responsible for the implementation of the acceptable plan correction.  5. Dates when the corrective action will completed. The corrective action dates must be acceptable to the State.  a. September 11, 2018	kly n d ion of		