STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER H & REHAB WEAVERV	78 WEAVER BLVD BOX 575 WEAVERVILLE, NC 28787

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #S47011.	F 000		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to place the survey results in an area that was readily accessible and available to residents. The findings are: Observation on 09/12/12 at 11:15 AM of the lobby area and foyer revealed no evidence of a notice posted where the State inspection results were located. On 09/13/12 at 10:30 AM an interview was conducted with the Activity Manager. She stated she attends Resident Council Meetings and for at least the last three months have not discussed with residents the location of the State inspection results. She said she	F 167	F167 1. Corrective action has been accomplished for the alleged deficient practice in regards to readily accessible survey results by moving the survey results location away from any potentially obstructing objects on 09/13/2012 by the Nursing Home Administrator. 2. All facility residents have the potential to be affected by the alleged deficient practice and corrective action was obtained by moving the location of the survey results location away from any potentially obstructing objects on 09/13/2012 by the Nursing Home Administrator. 3. Measures put into place to ensure that the alleged deficient practice does not recur include a survey results posting review during facility environmental rounds weekly to be completed by the Nursing Home Administrator, Social Worker, and/or designee.	10-8-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony J. Abola (for William L. Fritts)	Administrator	10-3-12

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.

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F 167	Continued From page 1 thought the State inspection results were located in the main lobby in a notebook. At 10:50 AM observation of the main lobby with the Activity Director revealed no evidence of a notice posted where the State inspection results were located and she was unable to determine where the inspection results were located. On 09/13/12 at 10:50 AM observation of the main lobby accompanied by the Activity Manager and Administrator revealed the State inspection results were placed in a a three ring binder hidden from view by a louvered door. The only indication the survey results were in the binder was a small typed "survey results" placed on the back of the binder. No other notice posting the location of the State inspection results was available. During this observation with the Administrator, he stated the survey results would be moved away from the louvered door in the lobby and placed in the lobby with a posted notice where they would be available and accessible to residents.	F 167	4. Data obtained during review will be analyzed for patterns/trends and reporting in Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance. 5. Date of Compliance: 10/08/2012 "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced	F 322	F 322 1. Corrective action has been accomplished for the alleged deficient practice in regards to following physician orders and practice guidelines for flushing a Gastrostomy tube for resident #60 by notifying the physician of the alleged deficient practice and administration of 120cc water flush per MD order by the licensed nurse on 09/12/2012.	10-8-12

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F 322	Continued From page 2 by:, Based on observations, staff interviews, and medical record review, the facility failed to flush a gastrostomy tube before and after administering medication and a bolus nutrient feeding for one (1) of one (1) resident observed with a gastrostomy tube. (Resident #60). The findings are: A facility Clinical Practice Standard for enteral nutrition dated December 2005 specified the gastrostomy tube (GT) should be irrigated (flushed) with 30 to 60 centimeters (cc) of tap water before and after administration of medications, before initiating a feeding, or as ordered by the physician. A review of Resident # 60's medical record revealed a physician's order dated 09/10/12. The order specified flush the GT with 30 cc of water before and after medication administration. The order also specified to flush with 120 cc of water before and after administering a bolus feeding. An observation of administration of medications and a bolus feeding was conducted on 09/12/12 at 10:01 AM. Licensed Nurse (LN) #1 was observed checking for GT placement and residual of bolus feeding by inserting a 60 cc syringe into the GT and aspirating. No residual feeding was noted. LN #1 then mixed the medication with a liquid nutrient (bolus feeding) and poured the solution into the barrel of the inserted syringe. When the medication/nutrient mixture was administered, LN #1 was observed pouring 60 cc of tap water into the inserted syringe. After the water was administered as a	F 322	2. Facility residents with Gastrostomy tubes have the potential to be affected by the alleged deficient practice. Corrective action was obtained for these residents by education for the licensed nurses on the facility practices regarding the use of Enteral Nutrition and Gastrostomy tubes conducted by the Staff Development Coordinator and Director of Nursing. 3. Measures put into place to ensure that the alleged deficient practice does not recur include education for the licensed nurses of facility practices regarding the use of Enteral Nutrition and Gastrostomy tubes conducted by the Staff Development Coordinator and Director of Nursing. The facility will also complete 5 med pass observation audits of licensed nurses to include administration of medications via Gastrostomy tubes weekly for a period of 4 weeks, then monthly for a period of 3 months. The DON, SDC, and/or Pharmacy Consultant will complete these audits. 4. Data obtained during audits will be analyzed for patterns/trends and reporting in Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will	

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F 322	Continued From page 3 flush for the GT, LN #1 removed the syringe from the GT tube and replaced the GT cap. An interview with LN #1 on 09/12/12 at 1:53 PM revealed he was not aware of the physician's order dated 09/10/12. He stated he did not flush the GT with 30 cc of water before and after medication administration. LN #1 added he did not flush the GT with 120 cc of water before and after administration of the bolus nutrient. An interview with the Director of Nursing (DON) on 9/13/12 at 4:49 PM revealed she expected licensed nurses to follow physician orders. The DON added she also expected GTs were flushed per facility protocol or physician's order.	F 322	evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance. 5. Date of Compliance: 10/08/2012 "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review, the facility intended to crush a medication listed on the Do Not Crush medication list for one (1) of twelve (12) residents observed receiving medications. (Resident #13) The findings are: A review of a facility list of Do Not Crush list of medications revealed Potassium Chloride was listed as a medication that should not be crushed. An observation of medication preparation for	F 333	F 333 1. Corrective action has been accomplished for the alleged deficient practice for resident #13 by notifying MD obtaining an order from the MD to change the form of the Potassium Chloride from pill to liquid on 10/03/2012. 2. Facility residents receiving medications that cannot be crushed have the potential to be affected by the alleged deficient practice. Corrective action for these residents was obtained by placing a list of "do not crush" medications in front of each MAR to identify medications that cannot be crushed. Licensed nurses will be educated by the Staff	10-8-12

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F 333	Continued From page 4 administration with Licensed Nurse (LN) #1 was conducted on 09/12/12 at 7:57 AM. LN #1 was observed placing various medications including Potassium Chloride into a plastic pouch. As he was placing the pouch into a device to crush pills, he was stopped by the surveyor. At this time LN #1 stated the pills had to be crushed for Resident #13 to swallow them. He was unaware Potassium Chloride in tablet form could not be crushed. An interview with the Director of Nursing (DON) on 09/12/12 at 8:20 AM revealed Potassium Chloride in tablet form should not be crushed. She stated there was a Do Not Crush list of medications on the front of each Medication Administration Record (MAR) notebook. The DON stated instructions for medication administration were not printed on individual resident MARs.	F 333	Development Coordinator and the Director of Nursing to use this list during medication administration to assist with proper administration. 3. Measures put into place to ensure that the alleged deficient practice does not recur include placing a list of "do not crush" medications list in front of each MAR to identify medications that cannot be crushed. Licensed nurses will be educated by the Staff Development Coordinator and Director of Nursing, to use this list during medication administration to assist with proper administration. The facility will also complete 5 med pass observation audits of licensed nurses weekly for a period of 4 weeks, then monthly for a period of 3 months. The DON, SDC, and/or Pharmacy Consultant will complete these audits. 4. Data obtained during audit will be analyzed for patterns/trends and reporting in Quality Assessment and Assurance (QA&A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance. 5. Date of Compliance: 10/08/2012	