STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345221	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/22/2013

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to place a psychiatric evaluation on the medical record for 1 of 1 sampled resident reviewed for behaviors. (Resident #156).

The findings included:

Resident #156 was admitted to the facility 06/03/13 with diagnoses which included Alzheimer's disease and cerebral degeneration. A quarterly Minimum Data Set (MDS) dated 08/29/13 indicated the resident's cognition was severely impaired. The MDS specified the resident demonstrated behaviors toward others, wandered daily, and rejected care.

A care plan dated 06/12/13 stated Resident #156 exhibited behavioral symptoms described as socially inappropriate and disruptive, refused care, wandered, and became agitated. The care plan goal specified the resident's behavioral episodes would decrease from once a day to once per week through the next 90 days. Approaches included administer medications as ordered.

A review of Resident #156's medical record revealed a note dated 10/03/13 and written by the Pharmacy Consultant. The Pharmacy Consult recommended the Attending Physician consider increasing the dose of Exelon (a medication used to improve overall function of persons with Alzheimer's disease). The Attending Physician indicated approval of the recommendation if the resident was referred to a consulting Psychiatrist for medication management. The Attending Physician signed the recommendation on 10/21/13.

Further review of the medical record revealed no documentation of a psychiatric evaluation and medication review.

An interview was conducted with the Social Worker (SW) on 11/21/13 at 2:50 PM. The SW stated Resident #156 was on a list provided to a new consulting psychiatrist on 11/04/13. The SW turned to a notebook kept in his office and found the written psychiatric evaluation. The evaluation dated 11/04/13 contained information regarding the resident's psychiatric history both present and past, medication review, blood analysis review, and recommendations for changes in treatment. The SW stated other physicians, pharmacists, or nurses would not have access to this information kept in the notebook in his office.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 1

An interview was conducted with Nurse #1 and Nurse #2 on 11/21/13 at 3:35 PM. Both nurses confirmed they were unaware Resident #156 had a psychiatric consult. Nurse #1 stated the Attending Physician would like to read the evaluation. Nurse #2 added the resident's behaviors escalated at night and she would have liked to read the Psychiatrist impression of this resident.

An interview was conducted with the Administrator on 11/21/13 at 4:45 PM. The Administrator acknowledged other physicians, nurses and pharmacist would not have access to psychiatric evaluations kept in a notebook in the SW's office. He stated the psychiatric evaluation should have been in the resident's medical record which was kept available on the nursing unit.

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 11/22/2013

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F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID# QKUH11.	F 000	1. All the residents identified needing a correction have discharged, therefore no opportunity to correct at the present time. 2. Any other resident(s) identified for the same opportunity of correction has been identified and corrected. The Business Office Director has been reeducated on the purpose and utilization of Non-Coverage letters. Going forward, the Business Office Director understands the importance of completing the block section indicating why Medicare will not be the primary pay source upon admission or during the residents stay The Business Office Director attended an in service on Monday, December 16th regarding Medicare Letters of Non-Coverage Policy and Procedure (OP2 0206.00). The Business Office Director will issue each resident entitled to Medicare Benefits, the appropriate notice upon	12/20
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christopher Murray TITLE: NHA (X6) DATE: 12/19/13

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.

DHSR NC Black Mountain WRO
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by: SKH

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156	admission, level of care change and/or discharge as applicable. The Regional Team consisting of and Area Collection Specialist and/or Regional Collection Manager will monitor the Notices issued on a monthly basis times two months to ensure compliance. Results of the observations will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months until substantial compliance has been achieved and maintained as determined by the QAPI committee.	12/20

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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to include a written reason Medicare services and benefits ended for 3 of 3 sampled residents who received Notice of Medicare Non-Coverage Letters and remained in the facility. (Residents #18, #59, and #71). The findings included: 1. Resident #18's Notice of Medicare Non-Coverage stated the notice was given on 09/16/13 that Medicare benefits would end on 09/19/13. There was no written reason Medicare was going to terminate payment provided in the notice. Interview on 11/21/13 at 3:27 PM with the Business Office Manager revealed that the therapy manager talked to the residents during therapy and the Social Worker informed the families and residents of the reason services and benefits were ending. She further stated she was new to the position and was not trained to include the reason for the termination of Medicare Benefits in the non-coverage letters. Per the Admissions Coordinator on 11/21/13 at 3:30 PM, Resident #18 met her maximum	F 156		

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F 156	Continued From page 3 potential in therapy and that was the reason Medicare benefits ended. Interview with the Therapy Manager on 11/22/13 at 10:10 AM revealed there was ongoing communication with residents and/or families about services and discharge plans. Interview with the Social Worker on 11/22/13 at 10:44 AM revealed that during the 72 hour care plan meetings, the residents and/or families were explained the process of skilled services and what would happen after therapy ended. Interview with the Administrator on 11/22/13 at 2:00 PM revealed the Business Office Manager was new to her position and still learning. 2. Resident #59's Notice of Medicare Non-Coverage stated the notice was given on 08/26/13 that Medicare benefits would end on 08/28/13. There was no written reason Medicare was going to terminate payment provided in the notice. Interview on 11/21/13 at 3:27 PM with the Business Office Manager revealed that the therapy manager talked to the residents during therapy and the Social Worker informed the families and residents. She further stated she was new to the position and was not trained to include the reason for the termination of Medicare Benefits in the non-coverage letters but that the Social Worker completed this letter. Per the Admissions Coordinator on 11/21/13 at 3:30 PM, Resident #18 met her maximum potential in therapy and that was the reason Medicare benefits ended.	F 156		

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F 156	Continued From page 4 Interview with the Therapy Manager on 11/22/13 at 10:10 AM revealed there was ongoing communication with residents and/or families about services and discharge plans. Interview with the Social Worker on 11/22/13 at 10:44 AM revealed that during the 72 hour care plan meetings, the residents and/or families were explained the process of skilled services and what would happen after therapy ended. Interview with the Administrator on 11/22/13 at 2:00 PM revealed the Business Office Manager was new to her position and still learning. 3. Resident #71's Notice of Medicare Non-Coverage stated the notice was given on 08/07/13 that Medicare benefits would end on 08/10/13. There was no written reason Medicare was going to terminate payment provided in the notice. Interview on 11/21/13 at 3:27 PM with the Business Office Manager revealed that the therapy manager talked to the residents during therapy and the Social Worker informed the families and residents. She further stated she was new to the position and was not trained to include the reason for the termination of Medicare Benefits in the non-coverage letters. Per the Admissions Coordinator on 11/21/13 at 3:30 PM, Resident #71 plateaued in therapy which was the reason Medicare benefits ended. Interview with the Therapy Manager on 11/22/13 at 10:10 AM revealed there was ongoing communication with residents and/or families	F 156		

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F 156	Continued From page 5 about services and discharge plans. Interview with the Social Worker on 11/22/13 at 10:44 AM revealed that during the 72 hour care plan meetings, the residents and/or families were explained the process of skilled services and what would happen after therapy ended. Interview with the Administrator on 11/22/13 at 2:00 PM revealed the Business Office Manager was new to her position and still learning.	F 156		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	1. The medication refrigerator on the 300 hall was replaced. The medications with manufacturer label which stated "store refrigerated at 36-46 degrees Fahrenheit were discarded on 11/21/13 by the Director of Nursing. 2. The remaining two medication refrigerators were checked by the Director of Nursing and noted to be 36-46 degrees Fahrenheit upon observation and temperature logs. 3. Licensed Nurse education included the following: A. Requirement that medication refrigerators temperatures must be maintained 36-46 degrees Fahrenheit. B. Temperatures must be checked and documented daily.	12/20

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F 431	Continued From page 6 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to maintain refrigerator temperatures between 36 - 46 degrees Fahrenheit for 1 of 4 medication refrigerators (300 hall). The findings included: On 11/21/13 at 9:37 AM, an observation of the medication refrigerator on 300 hall revealed a temperature of 32 degrees Fahrenheit (F). A review of the refrigerator temperature logs revealed documentation of temperatures below 36 degrees F 33 times since September 1, 2013. The logs did not indicate any action was taken to adjust the temperature. The refrigerator contained a box of Foradil Aerolizer containing 38 capsules with a manufacturer label which stated: "store refrigerated at 36 - 46 degrees Fahrenheit." On 11/21/13 at 1:20 PM, an observation of the medication room refrigerator revealed a temperature of 26 degrees F. An interview on 11/22/13 at 1:05 PM with Nurse #3, who was regularly assigned to work the 7:00 AM to 3:00 PM shift on the 300 hall, revealed she	F 431	C. If temperatures are noted to be outside acceptable parameters, refrigerator temperature control should be altered and temperature rechecked and documented. If acceptable temperatures cannot be maintained, medications should be removed and placed in an alternate medication refrigerator with acceptable temperatures. D. A maintenance requisition should be completed and placed in designated area for maintenance director to resolve The education was provided by the Staff Development Coordinator/designee and completed by 12/20/13. Any nurse not receiving education by 12/20/13 will received prior to next scheduled shift. New hires will receive this education during New Hire Orientation. Director of Nursing/designee will monitor refrigerator temperatures by observing a current temperature and reviewing temperature logs two (2) times per week for four (4) weeks, then weekly for two (2) additional months.	12/20

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F 431	Continued From page 7 was aware there was a problem with the refrigerator temperature 2 or 3 months ago. She stated she came on duty that day and the nurse who worked the 11:00 PM to 7:00 AM shift told her there was a problem with the temperature of the refrigerator and she had moved all the medication from that refrigerator to another medication refrigerator. Nurse #3 stated the former Director of Nursing (DON) plugged the refrigerator back in and checked it several times during that day and thought the refrigerator was functioning at the proper temperature so it was put back in use. Nurse #3 stated she wasn't aware there had been any further problems with the temperature being too cold until the surveyor brought it to her attention on 11/21/13.	F 431	Results of the monitoring will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months until substantial compliance has been achieved and maintained as determined by the QAPI committee.	12/20
441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	1. The glucometer was disinfected per policy using Sani Plus, the facility product that is EPA registered as tuberculocidal, effective against HIV, HBV and a broad spectrum of bacteria. The nurses identified not disinfecting per policy were re-educated on 11/2013 and 11/21/13 by the Staff Development Coordinator (SDC) with a return demonstration. The "tubs" of Epi-Cleanse were discarded from the facility and will no longer be ordered. 2. The remaining medication carts were audited for acceptable disinfectant (Sani-Plus).	12/20

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F 441	Continued From page 8 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to disinfect a glucometer (used for blood sugar monitoring) with a germicidal agent following a finger stick blood sugar for 1 of 1 sampled resident observed for blood glucose monitoring. (Resident # 149). The findings included: The facility policy titled "Cleaning and Disinfecting Glucometers Checklist" with a revision date October 2012 specified glucometers were to be cleaned after each use and placed in a case. The glucometer was to be disinfected using a disposable germicidal wipe (a wipe that is EPA registered as tuberculocidal; effective against HIV, HBV, and a broad spectrum of bacteria) by wiping the monitor and ensuring monitor was visibly wet. The policy specified the monitor could	F 441	3. Licensed Nurse education included: A. The facility process for disinfecting with appropriate germicidal wipe, leave it wrapped for 2 minutes and allow it to air dry. B. If the appropriate disinfecting agent is not available, a member of nursing managements should be notified. Licensed nurses were educated by the SDC/designee and completed by 12/20/13 Any nurse not receiving the education by 12/20/13 will receive education prior to next scheduled shift. New hires will receive this education in New Hire Orientation. The SDC/designee observed return demonstrations of glucometer cleaning by the Licensed Nurses by 12/20/13 The Director of Nursing/designee will randomly observe two (2) Licensed Nurses per week for four (4) weeks then two (2) nurses monthly for 2 additional months.	12/20

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F 441	Continued From page 9 be wrapped in a wipe in order to ensure it stayed wet for 2 or 5 minutes, depending on which germicidal disposable wipe was used. The monitor was to be stored in a case, clean and ready for the next use. On 11/20/13 at 4:32 PM, Nurse #4 on the 400 hall was observed completing a finger stick blood sugar on Resident #149. Nurse #4 exited Resident #149's room at 4:43 PM and cleaned the glucometer with a 65% alcohol wipe. An interview was conducted with Nurse #4 at the time of this observation. Nurse #4 stated she routinely cleaned the glucometer after each resident by wiping the surface of the glucometer then wrapping it in a wipe and leaving it in a plastic bag to dry. Review of Nurse #4's medication cart at the time of the observation did not reveal a supply of germicidal wipes on hand. Nurse #4 stated she had one more resident who needed a finger stick blood sugar before dinner. On 11/20/13 at 4:57 PM Nurse #4 removed the glucometer from the plastic bag and stated she was going to check the next resident's blood sugar. Prior to Nurse #4 checking the next resident's blood sugar, she was informed by the surveyor that 65% alcohol wipes were not an approved germicidal agent. Nurse #4 stated the 65% alcohol wipes were not on the medication cart on 11/19/13 and that she had used germicidal wipes, which was the product that was normally on the cart, prior to 11/20/13. Nurse #4 obtained a container of germicidal wipes and cleaned the glucometer with the germicidal wipe prior to use on the next resident. An interview on 11/21/13 at 8:10 AM with Nurse #5, who regularly worked the 7:00 AM to 3:00 PM shift revealed she had not seen 65% alcohol	F 441	Results of the observations will be presented to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months until substantial compliance has been achieved and maintained as determined by the QAPI committee.	12/20

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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 441	Continued From page 10 wipes on the medication cart until she came on duty on 11/20/13 at 7:00 AM. She stated she thought the facility had changed products because she had always had germicidal wipes before. She stated that she checked 2 residents fingerstick blood sugars on 11/20/13 prior to lunch and cleaned the glucometer with the 65% alcohol wipes each time. She stated she wasn't aware it wasn't an approved disinfecting agent. An interview on 11/22/13 at 11:55 AM with the Director of Nursing about her expectation for cleaning of glucometers revealed she expected staff to clean the glucometer after each use with a germicidal wipe, leave it wrapped for 2 minutes and allow it to air dry before using it for another resident. She confirmed that staff should not use the 65% alcohol wipes for disinfecting glucometers.	F 441		