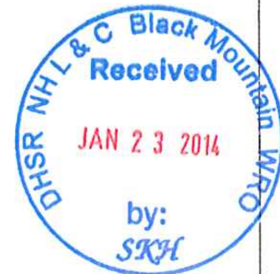
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING ______ B. WING ______	C 01/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVE PLACE NW HICKORY, NC 28601

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, and family and staff interviews, the facility failed to notify an interested family member of a new medication for pain	F 157	1. Resident #3 was discharged from the facility on 12/7/13. 2.The Director of Nursing or designee will perform a 100% audit of physician's orders received in the last 14 days to ensure interested family members or responsible parties have been notified of new physician's orders and medication changes. The audit will be completed by January 30, 2014.  	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey R Barlo LNHA
TITLE: LNHA
(X6) DATE: 1/20/14

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 157	Continued From page 1 ordered by the health care provider for 1 of 3 sampled residents (Resident #3). The findings included: Resident #3 was admitted on 11/21/13 with diagnoses including back pain, abdominal pain, joint pain, and pressure ulcer. An admission Minimum Data Set (MDS) dated 11/28/13 revealed Resident #3 had severely impaired cognition and was able to make her needs known. The admission MDS indicated Resident #3 received scheduled and as needed medications for pain in the last five days. In addition, Resident #3 reported frequent pain that limited day to day activities with an intensity of "8" on a scale of 1 to 10. Further review of the medical record revealed contact information for three family members. Review of the medical record revealed a physician's order dated 11/26/13 for Neurontin 100 mg (milligrams) by mouth twice daily for 3 days, Neurontin 200 mg by mouth twice daily for 3 days, then Neurontin 400 mg by mouth twice daily for pain which was noted by Nurse #1 on 11/26/13. Review of nurse's notes from 11/26/13 through 12/04/13 revealed no documentation that family was notified when the nurse practitioner (NP) ordered the Neurontin on 11/26/13. On 12/05/13 at 7:00 PM Nurse #2 noted a family member asked for Resident #3's Neurontin to be held due to an adverse reaction to the medication in the past. Nurse #2 further documented she would leave a note for the NP in the morning. Review of the 24 hour nursing reports for	F 157	3. All licensed nursing staff will be re-educated by the Assistant Director of Nursing or designee on notifying interested family members or responsible parties of all new physician's orders and medication changes. The education will be completed by January 30, 2014. The Director of Nursing or designee will audit new physician's orders 3 times per week for 4 weeks, then weekly for 8 weeks to ensure interested family or responsible parties have been notified of new orders or medication changes. Corrections will be made daily as opportunities are identified. 4. The results of the audits will be reported by the Director of Nursing in the monthly Quality Assurance Committee meeting for 3 months and then quarterly. The committee will evaluate and make further recommendations as indicated. Date of compliance is January 30, 2014. Date of Compliance: January 30, 2014	

QRB 1/20/14

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F 157	Continued From page 2 12/05/13 through 12/07/13 revealed a notation to hold Resident #3's Neurontin. An interview with Resident #3's family member on 01/02/14 at 10:30 AM revealed he noticed her hands jerking one day and reported this to the nurse. The family member asked if Resident #3 was on any new medications and was informed by the nurse she was receiving 400 mg of Neurontin twice a day for pain. The family member stated he visited frequently and had not been notified when Resident #3 was started on Neurontin for pain. The family member further stated if any one of the interested family members had been notified they would have refused to let her take the medication due to an adverse reaction Resident #3 had years ago. During an interview on 01/02/14 at 3:20 PM Nurse #2 revealed a family member reported Resident #3's hands were jerking on 12/05/13. Nurse #2 stated she assessed the resident and did not note any jerking movements. Nurse #2 recalled the family member asked about new medications and requested the Neurontin be discontinued because Resident #3 had trouble taking this medication in the past. The interview further revealed Nurse #2 had already given the evening dose of the Neurontin but she put a note in the physician's communication book. An interview was conducted with Nurse #1 on 01/02/14 at 4:40 PM. During the interview Nurse #1 reviewed Resident #3's medical record and confirmed he had signed off the order for Neurontin on 11/26/13. Nurse #1 stated when nurses' sign off a new medication order they were expected to contact family and document this in the nurses notes. Nurse #1 stated he did not	F 157		

JRB 1/20/14

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F 157	Continued From page 3 contact Resident #3's family regarding the Neurontin order written on 11/26/13 and could not recall if he asked the assigned nurse to notify her interested family member. During an interview on 01/02/13 at 5:52 PM the Director of Nursing (DON) stated the nurse who signed off a physician's order for a new medication was expected to notify the resident's family and document this in the nurse's notes.	F 157		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the morning medication pass, staff interview and record review, the facility failed to ensure a medication error less than 5%. There were 2 errors in the administration of inhalant medications out of 27 opportunities which resulted in a medication error rate of 7.4% (Resident #7). The findings included: 1. Resident #7 was admitted to the facility on 12/16/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of physician's orders dated 12/16/13 revealed medications for treatment of COPD included inhalation of one puff of Advair Diskus 500-50 micrograms daily.	F 332	1. A Medication Variance Form was completed by the Director of Nursing on January 2, 2014 regarding the administration of inhalers for resident #7. The Physician was notified by the Director of Nursing on January 2, 2014 2. Residents receiving inhalers have the potential of being affected by this alleged deficient practice.	

QNB 1/20/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 332	Continued From page 4 Review of Resident #7's January 2014 Medication Administration Record revealed direction to rinse mouth after use of the Advair Diskus inhaler. Review of the facility's procedure for administration of inhalant medication revealed direction to ask "the resident to exhale fully to empty the lungs." Observation on 01/02/14 at 9:44 AM revealed Medication Aide (MA) #1 administered the Advair Diskus to Resident #7. MA #1 did not ask Resident #7 to exhale prior to the administration of the inhaler. MA #1 proceeded to administer a second inhalant medication (Spiriva) and a topical medication (Nicotine patch). MA #1 exited the room. Interview on 01/02/14 at 9:51 AM with MA #1 revealed she was not aware of the need to exhale prior to administration of inhalant medication. MA #1 explained Resident #7 received thickened liquids so the mouth rinse after inhalation could not occur. Interview with the Director of Nursing (DON) on 01/02/14 at 11:20 AM revealed she expected staff to ask residents to exhale prior to administration of inhalant medication and provide assistance with a mouth rinse after administration. The DON reported the requirement of thickened liquids would not prevent a mouth rinse. 2. Resident #7 was admitted to the facility on 12/16/13 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD).	F 332	3. All licensed nursing staff and certified medication aides will be re-educated by Director of Nursing or designee on techniques for accurate administration of inhalers. The education will be completed by January 30, 2014. The Director of Nursing or designee will randomly observe 10 medication passes weekly for 4 weeks and then monthly for 2 months to verify proper medication administration techniques, including the administration of inhalers. Opportunities identified during audits will be corrected when observed. 4. The results of these observations and audits will be reported by the Director of Nursing during monthly Quality Assurance Committee meeting for 3 months then , quarterly. The committee will make changes or recommendations as indicated. Date of compliance will be January 30, 2014.	

grb 1/20/14

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F 332	Continued From page 5 Review of physician's orders dated 12/16/13 revealed medications for treatment of COPD included Spiriva 18 micrograms with hand held inhaler daily. Review of the facility's procedure for administration of inhalant medication revealed direction to ask "the resident to exhale fully to empty the lungs." Observation on 01/02/14 at 9:48 AM revealed Medication Aide (MA) #1 administered Spiriva to Resident #7. MA #1 did not ask Resident #& to exhale prior to administration. After the administration, MA #1 applied a topical medication (Nicotine patch) and exited the room. Interview on 01/02/14 at 9:51 AM with MA #1 revealed she was not aware of the need to exhale prior to administration of inhalant medication. MA #1 explained Resident #7 received thickened liquids so the mouth rinse after inhalation could not occur. Interview on 01/02/14 at 11:20 AM with the Director of Nursing (DON) revealed she expected staff to ask residents to exhale prior to administration of inhalant medication and provide assistance with mouth rinse after adminstration. The DON reported the requirement of thickened liquids would not prevent a mouth rinse.	F 332	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

JAB 1/20/14