STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe and/or clarify medication doses correctly for 2 of 12 sampled residents reviewed for medication transcriptions. (Residents #8 and #15). The findings included: 1.a. Resident #15 was admitted to the facility on 06/16/14 with diagnoses including seizures, diabetes, hypertension and chronic airway obstruction. Included in the hospital discharge instructions dated 06/16/14 were the medications: *carbamazepine (for seizures) tab 200 milligrams (mg) 3 times per day (TID); and *cyanocobalamin (vitamin B12) tab 1000 micrograms (mcg) daily. Review of the handwritten admission orders dated 06/16/14 that were carbon copied to the Medication Administration Record (MAR) and faxed to the pharmacy by Nurse #1 revealed the medications transcribed incorrectly as follows: *carbamazepine 1000 mg TID; and *cyanocobalamin 1000 mg daily. Review of the MAR revealed the incorrect dosage of carbamazepine 1000 mg (5 times the ordered dosage) was administered twice on 06/17/14	F 281	F 281 Services Provided Meet Professional Standards Resident # 8- medication variance completed. MD and family notified. Order corrected, faxed to pharmacy and MAR corrected. Resident # 15- no longer resides in the facility. Residents who have prescribed medication have the potential to be affected. A member of the nurse management team will review current residents orders to validate that transcription is accurate. Review will include comparison of medication orders on the discharge summary to the MAR on new admission charts. A nurse management team member will sign and date the orders once reviewed. Any discrepancies found will result in notification of physician/FNP, resident and family/POA. A medication variance form will be completed. The nurse responsible for the discrepancy will be re-educated on transcription and prevention of medication errors. Disciplinary	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luther Reeves | TITLE: Administrator | (X6) DATE: 8/22/2014

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 Mail Log Black Mountain Received AUG 25 2014 by: PAM

Original Signature: 8-21-14

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F 281	Continued From page 1 when it was identified as an error. The carbamazepine was held for 2 doses. Laboratory results dated 06/18/14 revealed the carbamazepine level was 7.5 ug/ml (within therapeutic range of 4.0 to 10.0 ug/ml) and was restarted correctly at 200 mg 3 times a day. The incorrectly transcribed cyanocobalamin "mg" versus the ordered dosage of "mcg" was not addressed. Phone interview on 07/31/14 at 2:44 PM with Nurse #1 who transcribed the orders dated 06/16/14 could not recall anything about these transcription errors. She stated she obtained the orders from the hospital discharge orders, verified the orders with the on call nurse practitioner, and another nurse was to check again and sign off on the orders. Review of the orders revealed no other nurse signed off on the 06/16/14 orders. b. Resident #15 was discharged to the hospital on 06/26/14 for altered mental status and suspected seizure and readmitted to the facility on 06/29/14. Review of the hospital discharge summary included the discharge medications as: *carbamazepine 200 mg 1 tab in the morning and 2 tabs in the evening; and *cyanocobalamin 1000 mcg daily. There was also a list of patient education medication list from the hospital which included different carbamazepine orders for 200 mg twice a day. Review of the handwritten readmission orders dated 06/29/14 that were carbon copied to the Medication Administration Record (MAR) and faxed to the pharmacy by Nurse #5 revealed the medications transcribed incorrectly as follows:	F 281	action will depend upon the discrepancy found. Orders of new admissions will be verified with the physician/FNP and noted by the admitting nurse. A second nurse will review to ensure transcription of orders is correct and sign MAR prior to faxing orders to pharmacy. The nurse management team will do a third transcription check during the clinical morning meeting on the next business day. A nurse management team member will sign and date the orders once reviewed. Any discrepancies found will result in the notification of physician/FNP, resident, family/POA. A medication variance form will be completed if applicable. The nurse responsible for the discrepancy will be re-educated on transcription and prevention of medication errors. Disciplinary action will depend upon the discrepancy found. Licensed nurses will be re-educated by members of the nurse management team on transcription and medication errors. Each nurse will attend and successfully complete the medication management course by August 28, 2014. Anyone not receiving the	

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F 281	Continued From page 2 *carbamazepine 200 mg every morning and evening; and *cyanocobalamin 1000 mg daily. There was no second nurse's signature on the transcribed physician orders dated 06/29/14. Review of the MAR revealed the incorrect dosage of carbamazepine 200 mg twice a day (missing 200 mg in the evening) was administered through the morning of 07/03/14 when Resident #15 was readmitted to the hospital. The incorrectly transcribed cyanocobalamin "mg" versus the ordered dosage of "mcg" was corrected to "mg when transcribed to the July 2014 MAR. Interview on 07/31/14 at 3:22 PM with Nurse #5 revealed she may have taken the carbamazepine orders off the discharge patient education medication list instead of the hospital discharge summary. She stated she could not recall. Interview with the Director of Nursing on 07/31/14 at 4:13 PM revealed that admission orders were not written up until the resident actually was admitted to the facility. She further stated the orders were supposed to be taken off of the hospital discharge summary and verified with the physician as those would be the most recent medication orders by the physician in the hospital. Interview with the pharmacist on 07/31/14 at 4:20 PM revealed that cyanocobalamin does not come in "mg" and it would have been corrected to "mcg"when the pharmacy printed the next MAR. He further explained only 1000 mg were sent from the pharmacy. On 08/01/14 at 9:46 AM the Director of Nursing stated during interview that if there was no	F 281	education by August 28, 2014 will receive prior to next scheduled shift. This information will be included in new hire orientation. The medication management course will include medication error prevention, ordering and receiving medications and medication administration. Members of the nurse management team will review new orders to ensure medication transcription is accurate and medications are started timely. Director of Nursing/designee will randomly select 5 MARS on each hall 3 times weekly for 4 weeks, then 1 time weekly for 2 additional months to review and ensure that medication transcriptions are accurate and medications are available and administered timely. Director of Nursing/designee will present findings of order audits to QAPI team monthly for 3 months or until substantiated compliance has been achieved and maintained as determined by the QAPI committee. "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	

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F 281	Continued From page 3 hospital discharge summary which included medication orders, the nurses were to verify the orders from the FL 2 form. She stated that all new orders were reviewed in morning meetings and that staff needed to pay more attention to the details of the orders. 2. Resident #8 was admitted to the survey on 07/15/14. Her diagnoses included dementia, degenerative joint disease, and arthritis. Review of the FL 2 revealed her medications included cyanocobalamin (vitamin B 12) 1000 mg (milligrams) every morning. The medication does not come in "mg" only micrograms (mcg). Review of the handwritten admission orders (not dated) that were carbon copied to the Medication Administration Record (MAR) and faxed to the pharmacy by Nurse #3 and signed off by a second nurse (Nurse #5) revealed the medications transcribed included: *cyanocobalamin 1000 mg daily. Interview with the pharmacist on 07/31/14 at 4:20 PM revealed that cyanocobalamin does not come in "mg" and it would have been corrected to "mcg"when the pharmacy printed the next MAR. He further explained only 1000 mg were sent from the pharmacy. Phone interview with Nurse #3 on 08/01/14 at 11:59 AM revealed she thought Nurse #5 transcribed the order but did not remember. She stated that she should have caught and clarified the cyanocobalamin "mg" transcription. Review of the orders revealed Nurse #5 cosigned the orders that Nurse #3 wrote. On 08/01/14 at 9:46 AM the Director of Nursing	F 281	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws."	8/28/2014

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F 281	Continued From page 4 stated during interview that if there was no hospital discharge summary which included medication orders, the nurses were to verify the orders from the FL 2 form. She stated that all new orders were reviewed in morning meetings and that staff needed to pay more attention to the details of the orders.	F 281		
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 record review and staff interviews, the facility failed to administer the correct dosage of a medication for 1 of 12 sampled residents reviewed for medication administration. Resident #15 did not receive the correct dosage of seizure medication after staff transcribed the dosage incorrectly twice. The findings included: 1.a. Resident #15 was admitted to the facility on 06/16/14 with diagnoses including seizures, diabetes, hypertension and chronic airway obstruction. Included in the hospital discharge instructions dated 06/16/14 was the medication: *carbamazepine (for seizures) tab 200 milligrams (mg) 3 times per day (TID). Review of the handwritten admission orders dated 06/16/14 that were carbon copied to the	F 333	F 333 Residents Free of Significant Medication Errors Resident # 15 no longer resides in the facility. Residents who have prescribed medications have the potential to be affected. A member of the nurse management team will review current residents orders to validate that transcription is accurate. Review will include comparison of medication orders on the discharge summary to the MAR on new admission charts. A nurse management team member will sign and date the orders once reviewed. Any discrepancies found will result in notification of physician/FNP, resident, and family/POA. A medication variance form will be completed. The nurse responsible for the discrepancy will be re-educated on	

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F 333	Continued From page 5 Medication Administration Record (MAR) and faxed to the pharmacy by Nurse #1 revealed the medication was transcribed incorrectly as: *carbamazepine 1000 mg TID. Review of the MAR revealed the incorrect dosage of carbamazepine 1000 mg (5 times the ordered dosage) was administered twice on 06/17/14 before it was identified as an error. The physician was notified and the carbamazepine was held for 2 doses. Laboratory results dated 06/18/14 revealed the carbamazepine level was 7.5 ug/ml (within therapeutic range of 4.0 to 10.0 ug/ml). Physician orders clarified the start of carbamazepine tab 200 mg 3 times per day. Phone interview on 07/31/14 at 2:44 PM with Nurse #1 who transcribed the orders dated 06/16/14 could not recall anything about these transcription errors. She stated she obtained the orders from the hospital discharge orders, verified the orders with the on call nurse practitioner, and another nurse was to check again and sign off on the orders. Review of the orders revealed no other nurse signed off on the 06/16/14 orders. During an interview on 08/01/14 at 11:16 AM, Nurse #2 who administered the first dose of carbamazepine 1000 mg on 06/17/14, stated he did not recall the tegretol administration. He further stated he was not that familiar with that medication and would not have questioned the dosage. On 07/31/14 at 4:42 PM nurse practitioner (NP) #1 stated during a phone interview that she received notification of the two incorrect doses of carbamazepine. Although she had never seen Resident #15 before, she was not terribly worried	F 333	transcription and prevention of medication errors. Disciplinary action will depend upon discrepancy found. Orders of new admissions will be verified with the physician/FNP and noted by the admitting nurse. A second nurse will review orders to ensure transcription of orders is correct prior to faxing orders to pharmacy. A nurse management team member will do a third transcription check during the clinical morning meeting on the next business day. The nurse management team member will sign and date the orders once reviewed. Any discrepancies found will result in notification of physician/FNP, resident, and family/POA. A medication variance form will be completed if applicable. The nurse responsible for the discrepancy will be re-educated on transcription and prevention of medication errors. Disciplinary action will depend on the discrepancy found. Licensed nurses will be re-educated by members of the nurse management team on transcription and medication errors. Each nurse will attend and successfully complete the medication	

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F 333	Continued From page 7 not written up until the resident actually was admitted to the facility. She further stated the orders were supposed to be taken off of the hospital discharge summary and verified with the physician as those would be the most recent medication orders by the physician in the hospital. On 08/01/14 at 10:56 AM, Resident #15's physician was interviewed. The physician stated he was made aware of the first dosage error when Resident #15 was administered 2 doses of carbamazepine 1000 mg. The physician stated the medication was subsequently held and laboratory testing came back with levels within the therapeutic range. The physician further stated that the excessive carbamazepine dose administered twice did not have an effect causing Resident #15's the hospitalization 9 days later on 06/26/14. In relation to the transcription error for carbamazepine of 06/29/14, the physician stated he ordered and expected Resident #15 to receive carbamazepine 200 mg 1 tab in the morning and 2 tabs in the evening. The physician stated that if there was a discrepancy between the discharge summary and the discharge medication list, the staff should clarify with the physician. The physician also stated that Resident #15's hospitalization on 07/03/14 was not a result of the decreased dose of carbamazepine because Resident #15 was also receiving Keppra another anticonvulsant which had been increased during the most recent hospital stay per the neurologist's consult.	F 333	constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws."	8/28/2014
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 8 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain physician ordered medications from the pharmacy for 1 of 12 sampled residents reviewed for medication administration. (Resident #15). The findings included: Review of the facility's policy Ordering & Receiving Medication, revised on January 2012, revealed information on what to do when a resident's medication needs have not been met by the facility's pharmacy. The section dealing with emergency back-up stated "It is unacceptable for nursing to state that medication was unavailable for administration. Our back-up process should be utilized in emergency	F 425	F 425 Pharmaceutical SVC-Accurate Procedures, RPH Resident # 15 no longer resides in the facility. Residents who have prescribed medications have the potential to be affected. Current resident's will have MAR to cart inventory completed to ensure medications are available and MARS reviewed to ensure that medications are being administered in a timely manner. Administrator and Director of Nursing met with the pharmacy director on August 11, 2014 to review medication order and delivery process. After hours and backup pharmacy process was reviewed as well. The Director of Nursing/designee will randomly select 5 MARS on each hall 3 times weekly for 4 weeks, then 1 time weekly for 2 additional months and review to ensure that medications are available and are being administered timely. Any discrepancies found will result	

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F 425	Continued From page 9 situations and when a delay in administration is anticipated." Step 1 was to locate the nearest pharmacy. Resident #15 was originally admitted to the facility on 06/16/14 with diagnoses including seizures, diabetes, dementia, congestive heart failure, hypertension and chronic airway obstruction. A SBAR Communication Form and Progress Note dated 06/26/14 at 3:00 PM noted Resident #15 was having issues of lethargy and altered mental status. The Resident transfer Form dated 06/26/14 stated the nurse practitioner (NP) went in to talk to Resident #15 and noted a change in his condition. The NP noted that he was lethargic, had a good grip in right hand, his left hand grip was weak, and he had participated in occupational therapy this morning. The change was noticed after lunch. Resident #15 was transferred and admitted to the hospital on 06/26/14. Resident #15 was readmitted to the facility on 06/29/14 at 2:00 PM per the Nursing Admission Intake Form. Per the hospital discharge summary dated 06/29/14, Resident #15 was treated for aspiration type pneumonia and possible seizure activity. Review of the hospital Discharge Summary, Resident #15's discharged medications included: *Aricept 10 milligrams (mg) daily; and *DuoNeb unit dose 4 times per day and every 2 hours as needed for dyspnea (uncomfortable breathing). Review of the transcribed physician orders dated 06/29/14 revealed both medications were	F 425	in the notification of the physician/FNP, resident and family/POA. A medication variance form will be completed as indicated. The nurse responsible for the discrepancy will be re-educated by on transcription and prevention of medication errors. Disciplinary action will depend upon discrepancy found. Licensed nurses and certified medication aides will attend and successfully complete and pass the medication management course. Re-education for all licensed nurses and certified medication aides regarding pharmacy policies will be completed by August 28, 2014. Anyone not receiving the education by August 28, 2014 will receive prior to next scheduled shift. This information will also be included in new hire orientation. The medication management course will include medication error prevention, ordering and receiving medications, and medication administration. Director of Nursing/designee will present findings of MAR audits to QAPI committee monthly for three	

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F 425	Continued From page 10 transcribed as ordered on the multi carbon copied Admission Orders sheet. This multi carbon copy sheet automatically transcribed the written orders to the Medication Administration Record (MAR) and a copy was faxed to the pharmacy. Review of the MAR for June 2014 revealed Resident #15 was to receive Aricept at 9:00 AM daily and the routine DuoNeb at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. The MAR revealed no initials were noted for the administration of DuoNeb on 06/29/14 or at 9:00 PM on 06/30/14. Nurse #2 initial and circled his initials for Aricept on 06/30/14 and DuoNeb on 06/30/14 at 9:00 AM, 1:00 PM, and 5:00 PM. The back of the MAR noted the circle initials indicated the medication was not available. Interview with the Director of Nursing (DON) on 07/31/14 at 3:13 PM revealed the admitting nurse was to fax the pharmacy a copy of the handwritten admission orders and the pharmacy normally delivered the medications in the evening. She stated if the pharmacy was not faxed before 5:00 PM, the pharmacy may not deliver all medications. If a medication was not available for some reason, the nurse should look in the medication cart for a backup supply. She stated she thought the DuoNeb would have been in backup supply. An interview was conducted on 07/31/14 at 3:22 PM with Nurse #5 who transcribed the admission orders including the Aricept and DuoNeb. Nurse #5 stated whoever worked on the evening of 06/29/14 should have documented the DuoNeb was not administered and the reason noted on the back of the MAR.	F 425	months or until substantiated compliance has been achieved and maintained as determined by the QAPI committee. "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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws."	8/28/2014

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F 425	Continued From page 11 Nurse #2, who initialed and circled the Aricept and DuoNeb on the MAR and noted the medication was not available, was interviewed via phone on 07/03/14 at 3:39 PM. Nurse #2 stated that if a medication was not available she should have checked the backup supply and/or call the pharmacy. He stated he could not recall the specifics of the medications in question for Resident #15. Follow up interview with the DON on 07/31/14 at 4:13 PM revealed the new admissions orders for Resident #15 were probably not faxed to the pharmacy until 3:00 PM on 06/29/14. she stated the pharmacy received the orders on 06/29/14 but for some reason the orders were kicked out of the pharmacy's system and had to be put back in their system on 06/30/14. The pharmacist stated on 07/31/14 at 4:20 PM that the medication arrived to the facility on 06/30/14. Follow up interview with Nurse #2 on 08/01/14 revealed he still could not recall about the medications, however the process would be to check the backup supply and inform the supervisor of the missing medications. He stated there was a way to get medications from the pharmacy immediately but that would be a judgement call as to the necessity of the medication for the resident. He further stated it was very rare for him to note that a medication was not available. Nurse #2 stated if Resident #15 was having problems breathing, he would have made sure he obtained the necessary medications. The DON further stated on 08/01/14 that Nurse	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 425	Continued From page 12 #2 should have told a supervisor or manager that the medications were not available, checked the backup supply and then check with the pharmacy.	F 425		