STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345250	A. BUILDING _____ B. WING _____	04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & RET/LINCOLNTON	515 S GENERALS BOULEVARD LINCOLNTON, NC 28093

(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 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		5/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/08/2015

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to conduct a comprehensive assessment for 4 of 5 sampled residents who received psychoactive medications to identify and analyze how condition affected each resident's function and quality of life (Residents #11, #79, #94 and #134). The findings included: 1. Resident #79 was admitted to the facility on 01/05/15 with diagnoses which included depression and post traumatic syndrome. Resident #79's medications included Risperdal 0.25 milligrams (mg.) daily (an antipsychotic) and bupropion 300 mg. daily for depression. Review of Resident #79's admission Minimum Data Set (MDS) dated 01/12/15 revealed an assessment of intact cognition. The MDS indicated Resident #79 received antipsychotic and antidepressant medications. Review of Resident #79's Psychotropic Drug Use Care Area Assessment (CAA) dated 01/16/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. There was no documentation of resident input or an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with Resident #79 on 04/23/15 at 2:34 PM revealed she relied on facility staff to administer medications and thought she no	F 272	F 272 " On 4-24-2015, T Goodson Resident Care Management Director (RCMD) reviewed the CAAs and care plans for residents # 11, #79, #94, #134 to ensure that their supporting documentation within the combined CAAs determined how the psychoactive medication affected the residents condition and if the facility had proceeded to care plan. Care plans were reviewed to ensure that appropriate interventions, related to how the psychoactive medication affected the residents condition, had been assessed and that appropriate interventions were in place. The facility did proceed to care plan on all four residents. " The facility identified other residents with the potential to be affected by the alleged deficient practice for comprehensive assessments by conducting the following: RCMD reviewing the CAAs and care plans for all residents on psychoactive medication to ensure that the supporting documentation within the combined CAAs did determine how the psychoactive medication affected the residents condition and if the facility had proceeded to care plan. Care plans were reviewed to ensure that appropriate interventions, related to how the psychoactive medication affected the residents condition, had been assessed and that appropriate interventions were in place. Each care plan was reviewed to	

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F 272	Continued From page 2 longer required medication for "her nerves." Interview with MDS Nurse #1, a licensed practical nurse, on 04/24/15 at 10:04 AM revealed she was not aware an analysis of Resident #79's information regarding behavior, psychiatric history and medication was required. Interview with the Administrator on 04/24/15 at 11:13 AM revealed an analysis of the findings should occur. The Administrator explained the CAA referred to data collection and findings by a psychiatric nurse practitioner. 2. Resident #11 was readmitted to the facility on 02/07/14 with diagnoses which included depression and dementia with behavior. Review of Resident #11's January 2015 physician's orders revealed direction for daily administration of Seroquel (antipsychotic) and Buspirone for anxiety. Review of Resident #11's annual Minimum Data Set (MDS) dated 01/19/15 revealed an assessment of moderately impaired cognition with no behaviors. The MDS indicated Resident #11 received antipsychotic and antianxiety medications. Review of Resident #11's Psychotropic Drug Use Care Area Assessment (CAA) dated 02/02/15 revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. There was no documentation of resident input or an analysis of the findings supporting the decision to proceed or not to proceed to the care plan.	F 272	ensure that appropriate interventions determined from the assessment had been taken to care plan and were in place. Audit was completed 5-8-2015. " Measures put in place to ensure that the alleged deficient practice for comprehensive assessments, does not recur include: The RCMD will educate the two MDS staff on the accurate completion for CAAs with documentation of the analysis to include how the condition affects the resident□s function and quality of life, such as weight loss, falls, change in ADLs. Education also includes that the documentation reflects where the information used for the CAA is located in the medical record. Weekly, the RCMD will spot check 50% of the CAAs for 12 weeks, for residents with psychoactive medications to ensure that the CAAs documentation includes the analysis of how the condition affects the resident□s function and quality of life, such as weight loss, falls, change in ADLs and that the documentation reflects where the information used for the CAA is located in the medical record. The RCMD will document her findings on a MDS Assessment worksheet. Any findings outside the above requirements will be addressed individually with the nurse completing the assessment and CAAs. * To monitor the effectiveness of the above action plan for comprehensive assessments J Smith, Administrator and RCMD will the review the findings of the weekly MDS worksheet in the QAPI	

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F 272	Continued From page 3 Interview with MDS Nurse #2, a Registered Nurse, on 04/24/15 at 10:08 AM revealed a documented analysis was not done. MDS Nurse #2 explained the CAA referred to documents which contained information and did not realize an analysis of the information was required. Interview with the Administrator on 04/24/15 at 11:13 AM revealed an analysis of the findings should occur. The Administrator explained the CAA referred to data collection and findings by a psychiatric nurse practitioner. 3. Resident #94 was admitted to the facility on 10/05/09 with diagnoses that included depressive disorder, anxiety, dementia and others. The annual Minimum Data Set (MDS) dated 12/17/14 specified the resident had moderately impaired cognition, had no documented behaviors but received antipsychotic, antianxiety and antidepressant medications daily. Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 12/30/14 revealed Resident #94's psychotropic drug use triggered for use of antipsychotic, antianxiety and antidepressant medications on a daily basis. Further review of the Psychotropic Drug Use CAA revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. There was no documentation of a gradual dose reduction attempt. Interview with MDS Nurse #1, a licensed practical nurse, on 04/24/15 at 10:04 AM revealed she was not aware an analysis of Resident #94's	F 272	meeting monthly for 3 months beginning 5/15/2015. The QAPI Committee will evaluate the effectiveness of the plan for comprehensive assessments and make recommendations for changes in the plan as indicated.	

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F 272	Continued From page 4	F 272		

information regarding behavior, psychiatric history and medication was required.

Interview with the Administrator on 04/24/15 at 11:13 AM revealed an analysis of the findings should occur. The Administrator explained the CAA referred to data collection and findings by a psychiatric nurse practitioner.

4. Resident #134 was admitted to the facility on 10/23/14 with diagnoses that included dementia, depression, anxiety and others. The admission Minimum Data Set (MDS) dated 10/30/14 specified the resident had moderately impaired cognition, had not documented behaviors but received antipsychotic, antianxiety and antidepressant medications.

Review of the Psychotropic Drug Use Care Area Assessment (CAA) dated 11/03/14 revealed Resident #134's psychotropic drug use triggered for use of antipsychotic, antianxiety and antidepressant medications on a daily basis.

Further review of the Psychotropic Drug Use CAA revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. There was no documentation of a gradual dose reduction attempt.

Interview with MDS Nurse #1, a licensed practical nurse, on 04/24/15 at 10:04 AM revealed she was not aware an analysis of Resident #134's information regarding behavior, psychiatric history and medication was required.

Interview with the Administrator on 04/24/15 at

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F 272	Continued From page 5 11:13 AM revealed an analysis of the findings should occur. The Administrator explained the CAA referred to data collection and findings by a psychiatric nurse practitioner.	F 272		