STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately assess the pressure ulcer status on the Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for pressure ulcers (Resident #3).	F 278	"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	11/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE:

(X6) DATE: 11/07/2016

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 278	Continued From page 1 Findings included: Resident #3 was admitted on 7/31/12 with diagnoses that included muscle weakness and bilateral knee contractures (shortening and hardening of the muscles). Review of the Wound Care Physician progress note dated 8/15/16 revealed Resident #3 was treated for an unstageable pressure ulcer on her left heel. The most recent MDS assessment dated 8/23/16 coded Resident #3 as severely cognitively impaired and displayed no rejection of care. The MDS indicated Resident #3 required extensive to total assistance with all activities of daily living. The MDS skin status section indicated there were no unhealed pressure ulcers. During an interview on 10/14/16 at 4:35 PM the MDS Coordinator confirmed that Resident #3 had an unstageable pressure ulcer on her left heel. The MDS Coordinator reviewed the MDS assessment dated 8/23/16 for Resident #3 and acknowledged it had been inaccurately coded for pressure ulcer status. An interview was conducted with the Administrator on 10/14/16 at 4:50 PM who stated it was her expectation for the MDS assessments to be accurately coded.	F 278	prepared by the provision of federal and state law." F278 1. Corrective action was accomplished for the alleged deficient practice in regard to resident #3's care plan by correcting Section M of the MDS. 2. All residents have the potential to be affected by the same alleged deficient practice. Measures put in place to ensure that the alleged deficient practice does not re-occur include: District Director of Clinical Services (DDCS) educated Resident Care Management Director (RCMD) on accurate coding of section M on MDS. 3. All current residents with wounds will be audited to verify accurate coding of section M on the MDS. DON or member of nurse administration team will audit 3 MDS section M weekly x1 month to verify accuracy, then 3 MDS every other week x 2 months. 4. Results of audits will be reported by the DON in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further recommendations as indicated.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		11/11/16

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F 280	Continued From page 2 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update the care plan to include the current interventions for a pressure ulcer for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #3). Findings included: Resident #3 was admitted on 7/31/12 with diagnoses that included muscle weakness and bilateral knee contractures (shortening and hardening of the muscles). The most recent Minimum Data Set (MDS) assessment dated 8/23/16 coded Resident #3 as severely cognitively impaired and displayed no rejection of care. The MDS indicated Resident #3	F 280	"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 by the provision of federal and state law." F280 1. Corrective action was accomplished for the alleged deficient practice in regard to Resident #3's care plan by updating to reflect current pressure ulcer and intervention to include treatment as ordered and bilateral pressure relieving	

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F 280	Continued From page 3 required extensive to total assistance with all activities of daily living. The MDS skin status section indicated she was at risk for development of pressure ulcers and there were no unhealed pressure ulcers. Review of Resident #3's skin care plan initiated on 10/26/15, with a recent review date of 9/22/16, indicated she was at risk for potential breakdown and skin impairment. Interventions included: notify the Physician of changes in wound or emerging wounds and perform skin checks weekly per facility protocol. Review of the facility's weekly pressure ulcer log for the period 10/5/16 through 10/12/16 revealed Resident #3 received treatment twice a day for an unstageable pressure ulcer on her left heel. Review of the Treatment Administration Record for October 2016 revealed an order dated 10/13/16 which indicated "paint left heel pressure ulcer with betadine, cover with foam, wrap with kerflix (gauze), and secure with tape every day shift for wound management." On 10/13/16 at 10:10 AM an attempt to interview Resident #3 was made but she was unable to answer questions. Resident #3 was observed in her wheelchair wearing foam boots on both feet. During an interview on 10/14/16 at 8:10 AM the Wound Treatment Nurse (WTN) indicated Resident #3 received betadine to her left heel twice a day. The WTN stated Resident #3 wore pressure relieving boots on both feet when sitting in her wheelchair. During an interview on 10/14/16 at 4:35 PM the	F 280	boots. 2. All residents have the potential to be affected by the alleged deficient practice. Measures put in place to ensure that the alleged deficient practice does not re-occur include: District Director of Clinical Services (DDCS) educated Resident Care Management Director (RCMD) on care plan accuracy to include current treatments and interventions for wounds. 3. DON or member of nurse administration team will audit all residents with pressure ulcers to ensure care plan is accurate to include treatment and current interventions. DON or member of nurse administration team will audit 3 skin care plans weekly x 4 weeks, the 3 skin care plans every other week x 2 months for accuracy. 4. Results of audits will be reported by the DON in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further recommendations as indicated.	

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F 280	Continued From page 4 MDS Coordinator confirmed Resident #3 had an unstageable pressure ulcer on her left heel. The MDS Coordinator reviewed the current skin care plan for Resident #3 and acknowledged it had not been updated to reflect current pressure ulcer interventions which included wound treatment as ordered and bilateral pressure relieving boots. An interview was conducted with the Administrator on 10/14/16 at 4:50 PM who stated it was her expectation for the care plan to be updated with current interventions.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow a care plan that specified the resident was to receive weekly skin checks for 1 of 3 residents reviewed for pressure ulcers (Resident #3). Findings included: Resident #3 was admitted on 7/31/12 with diagnoses that included muscle weakness and bilateral knee contractures (shortening and hardening of the muscles). The significant change MDS assessment dated 5/30/16 coded Resident #3 as severely	F 282	"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 by the provision of federal and state law." F282 1. Corrective action was accomplished for the alleged deficient practice in regard to Resident #3's skin assessment by completing skin assessment on 10/10/16.	11/11/16

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F 282	Continued From page 5 cognitively impaired and displayed no rejection of care. The MDS indicated Resident #3 required extensive to total assistance with all activities of daily living and was incontinent of both bladder and bowel. The MDS skin status section indicated she was at risk for development of pressure ulcers and there were no unhealed pressure ulcers. Review of Resident #3's skin care plan, with a revised date of 6/10/16, indicated she was at risk for potential breakdown and skin impairment. Interventions included: notify the Physician of changes in wound or emerging wounds and perform skin checks weekly per facility protocol. Review of the Wound Care Physician progress note dated 7/18/16 revealed Resident #3 was evaluated for a new pressure ulcer on her left heel that measured 3 cm x 2 cm. Review of the facility's Head to Toe Skin assessments for Resident #3 revealed the following: · 2 skin assessments were completed in June on 6/6/16 and 6/26/16. · 1 skin assessment was completed in July on 7/9/16 · 1 skin assessment was completed in August on 8/5/16. · 2 skin assessments were completed in September on 9/17/16 and 9/25/16. · 2 skin assessments were completed in October on 10/3/16 and 10/10/16. On 10/13/16 at 10:10 AM an attempt to interview Resident #3 was made but she was unable to answer questions. Resident #3 was observed in her wheelchair wearing foam boots on both feet.	F 282	2. All residents have the potential to be affected by the same alleged deficient practice. Measures put in place to ensure the alleged deficient practice doesn't occur include: Staff Development Coordinator (SDC)/Designee re-educated all licensed nurses on the completion of timely skin assessments to include - accurate and complete documentation of observations noted, documentation of observations on the TAR and the skin assessment worksheet, obtaining a physician's order for any treatment put in place and RP notification of any skin issues or treatment orders. All residents will have a skin assessment completed by 11/7/16. 3. DON/Designee will audit 5 residents weekly x 4 weeks, then 5 residents every other week x 2 months to ensure skin assessments are completed and any findings are documented timely and accurately. 4. Results of audits will be reported by the DON in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further recommendations as indicated.	

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F 282	Continued From page 6	F 282		

On 10/13/16 at 12:43 PM Resident #3 was observed in her wheelchair wearing foam boots on both feet.

During an interview on 10/14/16 at 8:10 AM the Wound Treatment Nurse (WTN) stated it was facility protocol to complete weekly skin assessments on every resident. The WTN stated she completed the weekly skin assessments for the residents listed on the pressure ulcer log and gave a copy of the log to each hall nurse. The WTN indicated the hall nurses were responsible for completing skin assessments for residents not listed on the pressure ulcer log.

On 10/14/16 at 10:08 AM observations were made of Resident #3's pressure ulcer on her left heel. The WTN removed the dressing from Resident #3's left heel which revealed an area of dark colored tissue that measured 0.3 cm x 0.3 cm. No signs of infection were noticed.

During an interview on 10/14/16 at 12:00 PM with Nurse #5 and Nurse #6 both confirmed it was facility protocol that all residents received weekly skin assessments. Both Nurse #5 and Nurse #6 stated the hall nurses were responsible for completing weekly skin assessments for residents not being followed by the WTN.

During an interview on 10/14/16 at 4:50 PM the Assistant Director of Clinical Services (ADCS) stated weekly skin assessments were to be completed on every resident and documented in the resident's medical record. ADCS was unaware Resident #3 had not received a skin assessment every week and would have expected for the nurse to complete skin

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F 282	Continued From page 7 assessments per facility protocol. During an interview on 10/14/16 at 4:50 PM the Administrator stated it was her expectation for staff to follow facility protocol and complete weekly skin assessments on every resident.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 329	"Preparation and/or execution of this plan	11/11/16

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F 329

Continued From page 8

facility failed to administer doses of medication as ordered by the physician for 2 of 6 residents reviewed for unnecessary medications (Residents #2 and #1).

The findings included:

1. Resident #2 was admitted to the facility 06/07/13 with diagnoses which included dementia, behavioral disturbances, and anxiety.

An annual Minimum Data Set (MDS) dated 05/07/16 indicated the resident's cognition was impaired and he required supervision with ambulation and other activities of daily living. The MDS specified the resident was able to make his needs known and usually understood others.

A review was conducted of Resident #2's medication administration record dated June 1 thru 30, 2016. Ativan gel 1 milligram (mg) per 1 milliliter (ml) to be applied topically to the resident's knee every 12 hours related to anxiety was documented. The original physician's order was noted to be 09/11/15. The Ativan gel was to be administered in the prescribed dose at 8:00 AM and 8:00 PM. The 8:00 PM dose on 06/09/16 was initialed as administered by Nurse #4.

Continued medical record review revealed a physician's order dated 6/10/16 at 12:00 AM instructing send Resident #2 to the hospital for evaluation and treatment.

A nurse's note dated 06/10/16 at 1:15 AM revealed Resident #2 received 10 ml (equivalent to 10 mg) of Ativan topical gel instead of 1ml (equivalent to 1 mg) of Ativan gel at 8:00 PM on 06/09/16. The occurrence was noted at 12:00 AM. The resident's vital signs were recorded within normal limits. The physician was notified and gave orders to send the resident to the hospital for evaluation and treatment. The note specified the resident had no change in functional or mental status and was alert and verbal.

F 329

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 by the provision of federal and state law."

F329

1. Corrective action was accomplished for the alleged deficient practice in regard to Resident #1 and #2 medications by completing medication variance reports. Resident #1 and resident #2 no longer reside at the facility.

2. All residents have the potential to be affected by the alleged deficient practice, therefore measures put in place to ensure the alleged deficient practice doesn't re-occur include: Nurse #4 was re-educated on medication error prevention on 6/11/16. Staff Development Coordinator (SDC)/Designee re-educated all licensed nurses on prevention of medication errors including transcription into the electronic medical record and verification for accuracy.

3. An audit will be completed on all current residents for any medication errors for the past 30 days.
DON/Designee will audit 10 MARS weekly x 4 weeks for medication errors, then 10 MARS every other week x 2 months.

4. Results of audits will be reported by

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F 329	Continued From page 9 A review of a report written by a hospital physician on 06/10/16 at 3:19 AM revealed Resident #2 was seen in the emergency room because of an accidental overdose of Ativan. The report specified the resident did not appear to be excessively sedated or more confused. The report further specified the resident was observed for 2 hours and had not shown any sedative side effects of benzodiazepine poisoning. Resident #2 was described as fully alert, oriented, and walking without assistance. A physician's progress note dated 06/10/16 and written by the facility Medical Director (MD) specified Resident #2 was assessed after a hospital visit for receiving a high dose of Ativan. The MD documented the resident's vital signs were within normal limits and he was in no obvious distress. A review of facility documentation revealed Nurse #4 was educated on medication error prevention. The in-service included the 5 rights when giving medication, categories of medication related problems, and tips to prevent medication errors. The document was dated 06/11/16 and signed by Nurse #4. An interview was conducted via phone with Nurse #4 on 10/14/16 at 11:59 AM. Nurse #4 stated she did accidently over medicate Resident #2 during administration of Ativan gel. She explained the Ativan gel came in a 10 ml syringe and was full when she used it on 06/09/16. When she administered the 8:00 PM dose of Ativan she applied the entire 10 ml of Ativan gel to the resident's knee instead of 1 ml. Nurse #4 stated she did not realize she had administered 10 mg of Ativan instead of the ordered 1 mg of Ativan until she started to sign out the medication on the controlled drug sign out sheet. When she realized she had made this error which was	F 329	the DON in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further recommendations as indicated.	

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F 329	Continued From page 10 several hours after she had administered the medication, she assessed the resident. Nurse #4 described the resident as easily aroused, alert and verbal. She then notified the physician and received orders at that time to send the resident to the hospital for evaluation and treatment. Nurse #4 added Resident #2 transferred himself to the wheelchair with assistance before being transported to the hospital. Nurse #4 stated she filled out a medication error report and received education from the facility regarding preventing medication errors. An interview was conducted with the Administrator and Assistant Director of Clinical Services (ADCS) on 10/14/16 at 1:32 PM. The ADCS explained how the facility identified medication errors. The Administrator added she was informed of medication errors when they were identified. Re-education was a part of the process the facility followed when addressing medication errors. One of the ways medication errors were identified was self reporting by the nurse that made the error. The ADCS stated she expected the nurses to notify the physician, family, and Director of Nursing when medication errors were identified. An interview was conducted via phone with the MD on 10/14/16 at 4:41 PM. The MD stated he was aware of the 10 ml of Ativan being administered to Resident #2 instead of 1 ml as ordered. He stated he assessed Resident #2 the morning after the overdose and found no harm was done to the resident. The MD added he had rather the nurse followed the order and administered 1 mg of Ativan gel. The Administrator and ADCS were unable to provide any documentation of other residents being audited for medication errors, all nurses being educated regarding medication errors,	F 329		

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F 329	Continued From page 11 monitoring of medication administration to ensure nurses were following correct procedures to prevent medication errors. 2. Resident #1 was admitted to the facility 09/12/16 with diagnoses which included acute on chronic kidney disease, diabetes and hypertension. A physician's progress note dated 09/20/16 noted Resident #1 was being seen to follow-up on concerns which included a chest X-ray showing mild congestive heart failure and lower extremity edema. The physician noted Resident #1 was not on diuretics and ordered Lasix (a diuretic) 40 milligrams (mg) for 2 days and then 20 mg thereafter. Review of the September 2016 Medication Administration Record (MAR) for Resident #1 noted 60 mg of Lasix (instead of 40 mg as ordered) was administered 09/21/16 and 09/22/16 and 20 mg thereafter. The electronic medical record noted the order for Lasix had been entered into Resident #1's record by Nurse #1. The order entry for the Lasix for Resident #1 read: -40 mg Lasix, every day for 2 days to begin 09/21/16 at 8:00 AM-09/22/16 at 11:59 PM -20 mg Lasix, every day at 9:00 AM to begin 09/21/16 On 10/14/16 at 1:32 PM the administrator identified Nurse #1 as an agency nurse. The	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING ______ B. WING ______	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 12 facility attempted to contact Nurse #1 for interview but those attempts were unsuccessful. On 10/14/16 at 2:20 PM Nurse #2 (that administered 60 mg of Lasix to Resident #1 on 09/21/16) stated she administered medications consistent with how they displayed on the electronic MAR. Nurse #2 reviewed the medical record of Resident #1 and verified the dosage of Lasix on 09/21/16 should have been 40 mg's, not 60 mg as given. Nurse #2 stated the 60 mg of Lasix was administered to Resident #1 on 09/21/16 because of how the medication was entered into the electronic medical record. Nurse #2 stated when an order was entered into the electronic medical record there was a second check to verify the accuracy of the order transcription. Nurse #2 reviewed the original Lasix order dated 09/20/16 for Resident #1 and noted an initial signature on the order and stated it was the signature of Nurse #3. Nurse #2 stated the nurse that completed the second check of an order would initial the order. On 10/14/16 at 4:20 PM the unit coordinator (over the unit Resident #1 had resided) and the Assistant Director of Clinical Services (ADCS) stated they were not aware Resident #1 received the wrong dose of Lasix on 09/21/16 and 09/22/16. The ADCS stated the second check of physician orders would include ensuring the medication, dosage and scheduling details were consistent with the physician order. The unit coordinator identified the initials on the Lasix order dated 09/20/16 for Resident #1 as those belonging to Nurse #3. The unit coordinator stated the initials were put on orders by the nurse that does the second check for accuracy of transcription into the electronic medical record.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 13 On 10/14/16 at 4:30 PM a phone interview was held with Nurse #3. Nurse #3 stated when a second check of orders was done she checked the medication, dosage and schedule against the original order. Nurse #3 could not recall if she checked the 09/20/16 order for Lasix for Resident #1 and stated since she couldn't see the actual order (via phone interview) she could not verify if she was the nurse that did the second check of the order. On 10/14/16 at 4:40 PM the physician of Resident #1 stated he expected medications to be given as ordered. The physician stated the dosage for Lasix ordered on 09/20/16 was for 40 mg for 2 days then 20 mg thereafter. The physician stated the extra 20 mg of Lasix administered 09/21/16 and 09/22/16 to Resident #1 would not have been a problem and he did not recall if he had been informed of the additional 20 mg given for 2 days.	F 329		