PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL IDENTIFICATION NUMBER: A. BUIL 345208 ME OF PROVIDER OR SUPPLIER RIAN CTR HLTH & REHAB BREVARD X4) ID SUMMARY STATEMENT OF DEFICIENCIES I I REGULATORY OR UST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (i) Certification	OMB NO. 0938- ULTIPLE CONSTRUCTION LDING IG IG STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278
PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL IDENTIFICATION NUMBER: A. BUIL 345208 ME OF PROVIDER OR SUPPLIER RIAN CTR HLTH & REHAB BREVARD X4) ID SUMMARY STATEMENT OF DEFICIENCIES I I REGULATORY OR UST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (i) Certification	LDING COMPLETED COMPLETED C G C 10 G STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712 D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CCOMPLIANT DEFICIENCY
ME OF PROVIDER OR SUPPLIER RIAN CTR HLTH & REHAB BREVARD X4) ID REFIX X4) ID REFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 278 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	IG 02/01/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712 D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLIANT
RIAN CTR HLTH & REHAB BREVARD X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IPRE TAG F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	STREET ADDRESS, CITY, STATE, ZIP CODE 115 N COUNTRY CLUB ROAD BREVARD, NC 28712 D PROVIDER'S PLAN OF CORRECTION (XE EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRE TAG F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	BREVARD, NC 28712 D PROVIDER'S PLAN OF CORRECTION (X4 EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIDER AG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) DEFICIENCY DEFICIENCY
X4) ID REFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRE TAG F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	D PROVIDER'S PLAN OF CORRECTION (XE EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
REFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PRE T/F 278 SS=D483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.(i) Certification	AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
SS=D ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	F 278 2/22/1
 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification 	
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification	
(1) A registered nurse must sign and certify that the assessment is completed.	
(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	
(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	
(i) 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	
(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.	
(2) Clinical disagreement does not constitute a material and false statement.This REQUIREMENT is not met as evidenced by:	
Based on medical record review, and staff interviews the facility failed to accurately code the	"Preparation and/or execution of this plan of correction does not constitute
RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	

Electronically Signed

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.

TATEMENT (TERS FOR MEDICARE & MEDICAID SERVICES IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY		
D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED			
				С		
	345208			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HLTH & REHAB BREVARD						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	
F 278	Continued From page	9 1	F 278	3		
	for 1 out of 4 sampled Findings included: Resident #3 was adm 4/29/15 with a diagno psychotic disorder an Minimum Data Set (M indicated Resident #3 care while a resident. Record review reveal signed by the doctor Resident #3 was adm 8/10/16. Record review further that indicated Reside visits in facility on 12/ During an interview o MDS Nurse indicated on Hospice and had r December 2016. The the quarterly MDS da inaccurately and shou received Hospice ser indicated a modificati completed. On 2/1/17 at 4:00 PM expectations were for	sis of vascular dementia, d heart failure. A quarterly IDS) dated 12/26/16 B did not receive Hospice ed a clarification order on 10/20/16 that indicated hitted to Hospice care on revealed Hospice notes nt #3 had received Hospice 21/16 and 12/22/16. n 2/1/17 at 11:55 AM the Resident #3 was currently received Hospice services in MDS Nurse went on to say ted 12/26/16 was coded uld have been coded to have vices. The MDS Nurse on MDS would be		 admission or agreement by the prothe truth of the facts alleged or conclusions set forth in the statement deficiencies. The plan of correction prepared and/or executed solely be it is required by the provision of fed and state law." 1. Corrective action was accomplis for alleged deficient practice in regaresident #3's MDS by correcting Set O. 2. All residents have the potential that affected by the alleged deficient practice does not re-occur include: Director of Nursin educated Resident Care Managem Director on accurate coding of sect on the MDS. 3. All current residents on Hospice audited to verify accurate coding of Section O on the MDS. DON/ADO audit 3 MDS Section O weekly x1 m to verify accuracy, then 3 MDS's evoluter week x 2 months. 4. Results of the audits will be reported by the Director of Nursing in the mod QAPI meeting x3 months. The QA committee will evaluate and make for recommendations as indicated. 	ent of is ecause eral shed ard to ection to be actices. the g ent ion O will be N will nonth rery ported porthly Pl	
F 514 SS=D		TE/ACCURATE/ACCESSIB	F 514		2/22/17	

Facility ID: 922995

If continuation sheet Page 2 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM): 02/20/2017 // APPROVED). 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED				
345208			B. WING		C 02/01/2017			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1	15 N COUNTRY CLUB ROAD			
BRIAN CTR HLTH & REHAB BREVARD				В	REVARD, NC 28712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	TIVE ACTION SHOULD BE COMPLETI CED TO THE APPROPRIATE DATE		
F 514	standards and practic maintain medical reco are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org (5) The medical recor (i) Sufficient informatic (ii) A record of the res (iii) The comprehensiv provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on medical re- interviews the facility administration of a pro-	n accepted professional res, the facility must ords on each resident that ented; e; and ganized d must contain- on to identify the resident; ident's assessments; we plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed as notes; and ogy and other diagnostic quired under §483.50. ' is not met as evidenced cord review, and staff failed to record escribed narcotic medication	F	514	"Preparation and/or execution of this p of correction does not constitute admission or agreement by the provide			
	by: Based on medical record review, and staff interviews the facility failed to record administration of a prescribed narcotic medication on the Medication Administration Record for 2 of 3 residents (Resident #1 and #2) reviewed for				of correction does not constitute	er of		

Facility ID: 922995

If continuation sheet Page 3 of 6

		MEDICAID SERVICES				D. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
					с	
345208		B. WING	02	/01/2017		
NAME OF PROVIDER OR SUPPLIER BRIAN CTR HLTH & REHAB BREVARD				STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
				115 N COUNTRY CLUB ROAD		
				BREVARD, NC 28712		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETIO DATE
F 514	Continued From page	e 3	F 51	4		
	medications.			deficiencies. The plan of	of correction is	
	Findings included:			prepared and/or execut		
		eadmitted to the facility on		it is required by the pro-	-	
		sis of cirrhosis of the liver.		and state law."		
		e Minimum Data Set (MDS)				
		t was moderately cognitively		1. Corrective action wa	•	
		ed Hospice care while a		for the alleged deficient		
	resident.	led a doctor's order for		to resident's #1 and #2 medication variance rep	, , ,	
		/1/17, for Morphine Sulfate		transcription error.		
		ive 10 milligrams (mg) by				
		is needed (PRN) for pain or		2. All residents have th	e potential to be	
	shortness of breath.			affected by the alleged	-	
	The narcotic sheet fo	r Resident #1 revealed		therefore, Nurse #1 and	d Nurse #2 were	
	Morphine Sulfate 10r	ng was given on 1/1/17 by		re-educated on appropriate		
		, 5:45 PM, and 6:45 PM.		documentation for prn r		
		edication Administration		administration. All licer		
		t indicate Resident #1 had		re-educated on appropr		
		ulfate 10mg at 4:45 PM, 5:45		of prn narcotic medicati		
	PM, and 6:45 PM on	n 2/1/17 at 3:10 PM, Nurse		documentation on the r form as well as transcri	-	
	•	not believe she missed		electronic medication a		
		N Morphine for Resident #1		record.		
		R but she could not swear to				
		to say she did document on		3. An audit will be com	pleted on current	
		r PRN Morphine on 1/1/17 at		residents receiving prn	-	
	4:45 PM, 5:45 PM, ar			past 30 days. DON/Nu		
		on 2/1/17 at 3:30 PM, The		audit 10 residents recei	01	
		DON) indicated Nurse #1 did		weekly x4 weeks, then	-	
		N Morphine on the MAR for		week x2 months to ens		
		7 at 4:45 PM, 5:45 PM, and urther stated the nurses		documentation to includ on the narcotic declinin		
		cument PRN medications on		transcription into the ele		
		. The DON indicated she		administration record.		
	expected for the docu					
		IAR and narcotic sheet to be		4. Results of the audits	s will be reported	
	correct.			by the Director of Nursi		
	On 2/1/17 at 4:00 PM	1 the Administrator stated her		QAPI meeting x3 month		
	expectations would b	e for the documentation of		committee will evaluate	and make further	1

Facility ID: 922995

If continuation sheet Page 4 of 6

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/20/2017 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED			
345208			B. WING			C 02/01/2017	
NAME OF PROVIDER OR SUPPLIER			_ [ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	•
BRIAN CTR HLTH & REHAB BREVARD			115 N COUNTRY CLUB ROAD				
BRIAN CIR HLIH & REHAB BREVARD							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 514	Continued From page	× 4					
F 514			F 5	14			
		be accurate and complete on c sheets. The Administrator			recommendations as indicated.		
		bected for the narcotic sheet					
	and the MAR to matc						
		dmitted to the facility on					
	1/26/16 with diagnosi						
	•	d 12/2/16 indicated the					
	resident was severely Record review reveal						
		5/17, for Morphine Sulfate					
		very 1 hour PRN for pain or					
	shortness of breath.						
		r Resident #2 revealed					
	-	ng given on 1/5/17 at 10:30					
	AM and 11:30 AM.	7 did pet indicate Decident					
		7 did not indicate Resident Aorphine Sulfate 10mg at					
	10:30 AM and 11:30						
		n 2/1/17 at 2:57 PM, Nurse					
		umented the PRN Morphine					
		e MAR and the narcotic					
		se #2 went on to say she					
	always tried to remen medications on the M	nber to document the PRN					
		n 2/1/17 at 3:30 PM, The					
	-	OON) indicated Nurse #2 did					
		N Morphine on the MAR for					
		7 at 10:30 AM and 11:30					
		stated the nurses were					
		nt PRN medications on the					
	MAR when given. The						
	expected for the docu	AR and narcotic sheet to be					
	correct.						
		I the Administrator stated her					
		e for the documentation of					
	•	be accurate and complete on					
		sheets. The Administrator					
	indicated that she exp	pected for the narcotic sheet					

Facility ID: 922995

If continuation sheet Page 5 of 6

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					/ APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391	
					CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _				
345208			B. WING			C 02/01/2017		
NAME OF PROVIDER OR SUPPLIER					IREET ADDRESS, CITY, STATE, ZIP CODE	02/	01/2011	
BRIAN CTR HLTH & REHAB BREVARD				115 N COUNTRY CLUB ROAD				
DRIAN CT				В	REVARD, NC 28712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	N SHOULD BE E APPROPRIATE		
					DEFICIENCY)			
F 514	Continued From page 5		F	514				
	and the MAR to matc	h.						

Facility ID: 922995

If continuation sheet Page 6 of 6