STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	**1086 MAIN STREET NORTH YANCEYVILLE, NC 27379**

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		5/19/17

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

Electronically Signed | 05/18/2017

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F 279	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to provide a written plan of care for end-of-life needs for one of one resident reviewed for hospice services (Resident #1). Findings included: Resident #1 was admitted 01/30/17. Diagnoses included Alzheimer ' s disease, malignant neoplasm of bronchus or lung, and personal history of malignant melanoma. The admission Minimum Data Sheet dated 02/03/17 indicated that her cognitive status was not able to be assessed. The resident needed extensive assistance for dressing, eating and toileting with total dependence for bathing.	F 279	F279: The facility Medical Director was notified of the absence of an end of life care plan for resident #1 on 4/11/2017. Facility residents who are provided hospice services have the potential to be affected by the absence of end of life care plan: An audit was completed for residents receiving hospice services to assure that end of life care plan had been written. Completed on 5/1/2017. Education was provided to licensed nursing staff and social work employees related to the writing of end of life care plans when hospice services are initiated.	

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F 279	Continued From page 2 The physician wrote an order for a "hospice consult" on 02/02/17, three days after admission. The resident was assessed and admitted to hospice services by [name of hospice service] on 02/05/17. A review of the record from 01/30/17 to 03/22/17 revealed that there was no written care plan in place that addressed end-of-life services including pain management related to the dying process. The Director of Hospice was contacted by phone on 04/27/17 at 4:40 p.m. She was able to provide a "Hospice Certification and Plan of Treatment" for Resident #1 dated 02/05/17 and signed by the Attending Hospice Physician. One of the interventions included: Nurses "to go out" as needed for pain and discomfort ...assess for pain and discomfort. In an interview with Hospice Nurse #2 on 04/25/17 at 11:15 a.m., he indicated that hospice nurses and aides gave a verbal report to the charge nurse after visiting residents receiving their services. The hospice nurses and aides did not write notes in the facility ' s chart for the residents. In an interview with the Administrator on 04/27/17 at 6:45 p.m., she shared her expectation that services for residents were coordinated between the facility and hospice and that the care plans developed were integrated for each resident.	F 279	Completed 4/28/2017. Orders written within the previous 24 hours will be reviewed daily in the clinical morning meeting (Monday - Friday) to determine the presence of hospice orders. The nurse manager on duty will review physician orders written on the weekend to determine the presence of hospice orders. An audit tool will be created to reflect compliance with the initiation of end of life care plan when hospice orders are obtained. Start date: 5/1/2017 The medical records of residents admitted to hospice services will be reviewed weekly by the DON or her designee to assure that residents admitted to hospice services have a written end of life care plan. Start date: 5/1/2017. The corrective action noted above will be reported monthly to the QAPI Committee for the next 3 months to assure maintaining the corrective action. This Plan of correction is the facilities allegation of compliance.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life	F 309		5/19/17

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F 309	Continued From page 3 Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to provide pain management as ordered by hospice for one of three residents reviewed for hospice services (Resident #1).	F 309	Tag 309: 1. The facility medical director was notified of the unavailability of end of life comfort medications related to resident	

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F 309	Continued From page 4 Findings included: A review of the contract between the facility and the hospice provider was conducted. Section 2.3 under Duties and Obligations of Hospice stated "Hospice agrees to provide all drugs and pharmaceuticals related to the management of the terminal illness and related conditions, which are specified in the Plan of Care for a Hospice Patient." Section 2.8 indicated that "Hospice will make nursing services, physician services, and drugs and biologicals routinely available on a twenty-four (24) hour basis." Resident #1 was admitted 01/30/17. Diagnoses included Alzheimer ' s disease, malignant neoplasm of bronchus or lung, and personal history of malignant melanoma. The admission Minimum Data Sheet dated 02/03/17 indicated that her cognitive status was not able to be assessed. The resident needed extensive assistance for dressing, eating and toileting with total dependence for bathing. The resident ' s undated care plan provided by the Assistant Director of Nursing did not address pain management issues related to end-of-life services. The resident was deceased at the time of the investigation. The resident was assessed by [name of hospice service] on 02/05/17 and admitted to their hospice services. The March 2017 Medication Administration Record (MAR) was reviewed. Resident #1 received a Tylenol suppository on 03/20/17 at 3:39 p.m. and her scheduled dose of Xanax at 9:00 p.m. on 03/20/17. Resident #1 ' s pain level	F 309	#1. The resident expired 3/22/2017. 2. Facility residents on hospice services have the potential to be affected by the unavailability of end of life comfort medications. 3. An ADHOC meeting was held with the medical director, hospice representatives and the nursing administrative team to clarify the facility process for obtaining orders for comfort medications and the obtaining of comfort medications as ordered for residents receiving hospice services. Completed on 4/7/2017. 4. The facility will maintain contracts only with hospice providers who will provide all pharmaceuticals on a 24 hour basis related to the management of the terminal illness and end of life comfort care. Completed 5/19/2017. 5. An audit of facility residents who receive hospice services was completed to assure assessment of pain, orders for appropriate comfort medications for end of life care, and the availability of medications. Completed 4/7/2017. 6. The facility Nurse Practitioner will review the medical records of residents receiving hospice services to assure that pain has been assessed and that orders for appropriate comfort medications have been written. Complete4d 4/10/2017. 7. Education will be provided to licensed nursing staff relative to pain assessment, MD notification, the process for obtaining medications, requiring hand written prescriptions and the notification of nursing management in the event of difficulty obtaining orders for comfort	

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F 309	Continued From page 5 was recorded as a 7 on a scale of 1 to 10 on second shift (03/20/17) and a level 5 on third shift (03/21/17). The MAR indicated that an order for morphine sulfate was entered on 03/20/17 at 9:46 p.m. but no administration to Resident #1 was recorded. There were no initials in place to indicate Resident #1 received morphine sulfate at any time on 03/20/17 until after 8:45 a.m. on 03/21/17 when the nurse practitioner provided a signed order for morphine and Hospice Nurse #2 arrived and administered the first dose. In an interview with Nurse #1 on 04/26/17 at 1:20 p.m., she stated that Resident #1 experienced a rapid physical decline following a diagnosed upper respiratory illness. She explained that the hospice nurse visited the facility to assess the resident on 03/20/17 at 6:30 p.m. Earlier that day a different hospice nurse had written orders for comfort medications to include morphine which was not available in the facility, nor had it yet been obtained for administration to the resident in the evening hours of Nurse #1 ' s shift. She stated she had multiple text interactions with the physician on-call in order to obtain a written and signed order for morphine to be faxed to the pharmacy so that it could be obtained and administered to the resident. This communication was documented in her late-entry progress note dated 03/20/17 at 10:18 p.m. In an interview with Hospice Nurse #1 on 04/26/17 at 5:15 p.m., she indicated that she was sent to the facility for a follow-up visit because Resident #1 was "actively dying" and had an elevated temperature. She indicated that on arrival at 6:30 p.m. on 03/20/17 Resident #1 was grimacing with "some distress" and pulled away from the touch of her hand. She estimated the	F 309	medications or the delivery of comfort medications. This education will be provided to all Licensed Personnel and newly hired licensed nursing personnel. Completed 4/13/2017. 8. The DON or her designee will audit residents on hospice services weekly for a period of three months to assure the availability of comfort care medications. An audit tool was created to reflect these findings. Start Date was 4/11/2017. The corrective action noted above will be reported monthly to the QAPI Committee for the next 3 months to assure maintaining the corrective action. This Plan of Correction is the facilities allegation of Compliance.	

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resident ' s initial pain level to be a "7" on a scale of 1 to 10. By the time she left the facility she judged her pain level to be a "2 or 3." The resident did not receive any morphine during the time of her visit as recommended by hospice. Hospice Nurse #1 acknowledged that the Contact Dates of "03/21/17" that she used in her documentation about the hospice follow-up were incorrect. Her facility visit to Resident #1 and subsequent phone contact with the hospice agency about the lack of medication actually occurred on the evening of 03/20/17, not on 03/21/17 as recorded in her documentation.

A transcript of pager texts between the facility nurse and on-call physician provided by the medical group was reviewed. Medications for comfort care were approved by the attending physician on 03/20/17 in the following text exchange:

From facility: "Awaiting confirmation on [Resident #1] ' s comfort meds, hospice ordered them, awaiting ok from dr. on call to order, please advise."

From Physician #1: "If hospice ordered them, that ' s fine."

In a later text exchange on 03/20/17 later that evening (no time provided on the pager transcript), the physician referred the nurse to hospice staff to provide the written prescription for the morphine. After multiple text interactions, the physician directed the nurse to have the pharmacy contact him directly.

A review of Resident 1 ' s record revealed no written and signed order for morphine was

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obtained on 03/20/17 after the series of text exchanges.

In an interview with the Physician #1 on 04/26/17 at 11:00 a.m., he stated the Pharmacy did not contact him to discuss the prescription needed for morphine for Resident #1. He stated he believed the matter was resolved since no one phoned him.

In an interview with staff member #1 of the medical group on 04/26/17 at 12:30 p.m., he acknowledged that the chronology of the pager texts was accurate but that the time stamps of the individual texts were not reliable when printed from the archives.

In an interview with the Director of Nursing on 04/27/17 at 1:55 p.m., she indicated that there were no written protocols for nurses on how to obtain medications after hours. She stated that morphine was not routinely kept in the facility.

Resident #1 was assessed for pain by the Nurse Practitioner on the morning of 03/21/17 at 9:15 a.m. She wrote and signed an order for "morphine sulfate solution 20 mg/ml - give 0.25 ml by mouth every 1 hour as needed for agitation/pain."

Hospice Nurse #2 indicated in his note of 03/21/17 that the resident had "some moaning and groaning" and received two doses of morphine 0.25 ml. during the time of his visit from 8:45 a.m. to 12:25 p.m. Resident #1 expired the following day at 8:05 p.m.

In an interview with the Director of the hospice service on 04/27/17 at 4:40 p.m., she indicated

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F 309	Continued From page 8 that hospice did not keep medications, store or provide them. Hospice team members assessed residents, recommended care, and wrote orders including medication orders but that the organization did not distribute medications. In an interview with the Administrator on 04/27/17 at 6:45 p.m., she shared her expectation that medication be provided to help control a resident ' s pain at the end of life.	F 309		