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 09/22/2017

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 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		10/20/17

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

Electronically Signed | 10/16/2017

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 09/22/2017

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 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 observations, record review, family interview and staff interviews, the facility failed to include psychoactive medications in an individualized care plan for 1 of 6 residents reviewed for unnecessary medications (Resident #165). The findings included: Resident #165 was admitted to the facility on 06/20/17 with diagnoses including history of dementia, symbolic dysfunctions, gait abnormality and ataxia. Resident #165's admission Minimum Data Set (MDS) assessment dated 06/27/17 revealed he had severe cognition impairment. The resident	F 279	F279 (D) Develop Comprehensive Care Plans How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The process that lead to deficiency practice: The MDS coordinator should have reviewed all the careplans to assure all CAA□s triggered were addressed and careplanned. On 9/21/17 , the comprehensive care plan for resident #165 was updated to include the use of Risperdone and Remeron,	

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 09/22/2017

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 279	Continued From page 2 was coded as displaying verbal behavior towards others and as rejecting care for 1 to 3 days of the assessment period with no risk to the resident or others. The MDS noted the resident with a history of a fall without injury before his admission to the facility and as receiving both antipsychotic and antidepressant medications for the full 7 day assessment period. Resident #165's Care Area Assessment (CAA) based on the MDS revealed the resident to have vascular dementia with known psychosis. Behaviors noted included rejection of care and wandering. The care area of falls was triggered due to weakness, abnormal gait and a lack of coordination. Psychotropic medication used at the time of the assessment included Geodon (an antipsychotic medication) and Trazodone (an antidepressant), with documentation that the facility would include this in the resident's care plan due to at risk for an adverse reaction related to psychotropic medications. Resident #165's care plan dated 07/06/17 included the problems of resistance to care related to adjustment to nursing home care, dementia, a new environment and wandering, with numerous non-medication interventions noted but no mention of psychoactive medication use. The problem of being at risk for falls included the intervention to observe ordered medications for side effects and effectiveness. A Progress Note date 06/20/17 documented Resident #165 as taking scheduled and as-needed Trazodone for agitation and anxiety, with the resident calling aloud to go home to see wife and pulling at objects, with staff able to calm and redirect him most of the time. A Pharmacy	F 279	psychoactive medications. On 9/21/17 , MDS coordinators #1 and #2 received a Teachable Moment on the requirement for inclusion of psychoactive medications on the comprehensive care plan. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/22/17 , comprehensive care plans for other residents receiving psychoactive medications were reviewed by the Resident Care Management Director (RCMD) to ensure care plans reflect psychoactive medications as necessary. Any identified issues were corrected immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/21/17 + 10/4/17 , licensed staff was re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F279 with emphasis on the inclusion of psychoactive medications on the comprehensive care plan. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The RCMD will randomly monitor corrective actions to ensure the	

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 09/22/2017

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 279	Continued From page 3 Review Consult dated 06/24/17 consult recommended a gradual dose reduction of Geodon. A Nurse Practitioner's note for Resident #165 dated 08/01/17 noted the resident as overall very lethargic compared to when he arrived to the facility and as no longer walking. A Palliative Care note dated 08/03/17 revealed that as compared to a previous visit two weeks prior, the resident was requiring more care with activities of daily living, sleeping most of the time and not responsive unless touched. This note documented a decrease in Geodon from 40 milligrams (mg) to 10mg. Review of a Psychiatric note dated 08/16/17 revealed Remeron (an antidepressant) was added at bed time for depression to help with his mood and appetite and his evening dose of Trazodone as decreased. Another Psychiatric note dated 08/23/17 revealed that due to sedation Geodon would be decreased to 10mg twice a day. Another Palliative Care note dated 09/05/17 revealed that since his last visit the resident had slightly more energy per facility staff, his Geodon was discontinued and he had Risperidone (another antipsychotic medication) started at 0.25mg twice daily, Remeron 15mg was started to be given every night and scheduled Trazodone was discontinued. Another Nurse Practitioner note dated 09/11/17 revealed the resident was much more alert on Risperidone that Geodon. Review of Resident #165's current medication orders dated 09/15/17 included discontinuing Risperidone 0.25mg twice a day and instead giving it once a day at bedtime at the 0.25mg dosage. Another order dated 09/15/17 was to give Trazodone 12.5mg every 12 hours as	F 279	effectiveness of these actions by randomly monitoring 3 different resident□s individualized care plans for inclusion of psychoactive medications 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Care Management to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	

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 09/22/2017

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 279	Continued From page 4	F 279		

needed for anxiety or behavior.

Observations of Resident #165 on 09/19/17 and 09/20/17 revealed him to be awake in his wheelchair, having a calm affect with no behaviors but as verbally non-responsive.

Telephone interview on 09/20/17 at 9:33 AM with a family member of Resident #165's revealed that his Geodon had been stopped and since then he was no longer getting agitated.

Interview with the Nurse Practitioner on 09/21/17 at 11:20 AM revealed that due to sedation concerns the Risperidone order for Resident #165 on 09/15/17 was changed from twice a day to once a day at bedtime.

Observation of Resident #165 on 09/21/17 at 2:29 PM revealed him in his wheelchair and visiting with a family member, awake, having a calm affect and responding to a greeting with a simple verbal response and a handshake.

Interview with MDS Coordinators #1 and #2 on 09/21/17 at 1:34 PM revealed the nurse admitting a new resident completed an initial care plan while they completed the final one in the computerized record. They stated they use the CAA to determine what to put in the care plan. They stated if psychotropic medications were triggered on the CAA it would be care planned, along with pertinent diagnoses related to the medication use, side effects to monitor, psychiatric services if needed, medication reviews and other reviews as indicated by the interdisciplinary team. They stated Resident #165 was due for a care plan review and had an MDS assessment in progress. They stated that

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 09/22/2017

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 279	Continued From page 5 when an MDS assessment was completed the computer program used would prompt them to consider updating the care plan. They stated a psychotropic care plan problem would catch all of the ordered and pertinent medications or they could break them out by drug class. They stated Resident #165 should have had a psychotropic care plan problem in his care plan. They stated that if Remeron was ordered for an appetite stimulant this would be added to the psychotropic problem or to a nutrition problem. They stated that nurses would enter order updates into the computerized record and they would be discussed at a morning clinical meeting. Interview with the Assistant Director of Nursing (ADON), Director of Nursing (DON) and the Corporate Nurse Consultant on 09/21/17 at 2:15 PM revealed psychotropic medications should be reflected in the care plan if triggered by the CAA. They stated Resident #165 should have had this care plan problem initiated upon admission for Geodon then show a revision when he was put on Risperidone. They stated the care plan should have reflected the order for Remeron for appetite stimulation as well.	F 279		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		10/20/17

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 09/22/2017

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	Continued From page 6 Based on record review, family interview, staff interviews and provider interviews, the facility failed to process and follow orders that discontinued an antihypertensive medication (Imdur), reduced the dosage for a non-narcotic sleep aid (Melatonin), reduced the frequency of administration of an antipsychotic medication (Risperidone) and increase vital sign frequency, in a timely manner and over a 3 day period, for 1 of 6 residents reviewed for unnecessary medications (Resident #165). The findings included: Resident #165 was admitted to the facility on 06/20/17 with diagnoses including history of a cerebral infarct, dementia, atherosclerosis, hypertension and gait abnormality. A medication order for Resident #165 dated 06/20/17 revealed the antihypertensive medication, Imdur 24 hour extended release, 15 milligram (mg) tablet, one tablet at bedtime. Review of a Nurse Practitioner note for Resident #165 dated 09/05/17 revealed that due to hypotension (low blood pressure), follow up would be made with a Cardiologist as the resident was on Imdur. An order dated 09/05/17 directed staff to make a follow up appointment with the Cardiologist related to Imdur, hypotension, fatigue, and coronary artery disease. An Emergency Department (ED) report dated 09/14/17 revealed Resident #165 arrived from a Cardiology clinic for low blood pressure in the 70s (systolic) over 50s (diastolic) with family noting increased somnolence for several days. The Cardiologist was reported to have concerns with	F 281	F281 (D) Services Provided Meet Professional Standards How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Process that lead to deficiency practice: Nurse that should have processed the order was distracted at busy nurses station. Third shift nurses did not check charts for new orders missed. On 9/18/17 , orders for Resident #165 were processed to include the following; discontinuation of Imdur, dose reduction for Melatonin, frequency reduction for Risperdone and increase in vital sign monitoring frequency. On 9/18/17 , Unit Manager #1 received a Teachable Moment on the expectation regarding timely processing of orders. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/18/17 , an audit was completed by, 2nd shift supervisor , to ensure no other orders were missed and/or outstanding. No other issues were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/4/17, licensed nurses were re-educated by the Director of Nursing	

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 09/22/2017

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	Continued From page 7 overmedication and the resident presented with no other signs or symptoms. The report stated his blood pressure improved since his arrival with the hospitalist team speaking to the Cardiologist. A recommendation was made to hold Imdur and to follow up as needed. A Nurse Practitioner note for Resident #165 dated 09/15/17 revealed the visit was a follow up after the resident's ED evaluation on 09/14/17. The note documented the resident as having hypotension and as being sent to the hospital from the Cardiologist's office with "BP in 70s [systolic]." The note further documented the Cardiologist had called the Nurse Practitioner with an update and the Assistant Director of Nursing (ADON) also as being notified. It was documented that per the Cardiologist, the Imdur was to be discontinued and vital signs checked twice a day for a week. The resident was noted to also be on Risperidone twice a day and notification would be made to the Psychiatrist to decrease the Risperidone. Orders for Resident #165 dated 09/15/17 included the following: discontinue Imdur, decrease Melatonin to 5mg dose at bedtime, discontinue Risperidone 0.25mg twice a day and start Risperidone 0.25mg at bedtime and obtain vital signs twice a day for one week then to have the Nurse Practitioner review them, related to hypotension on 9/14/17. The Medication Administration Record (MAR) for Resident #165 for September 2017 revealed Imdur extended release 24 hour, 15mg was documented as administered at 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed Melatonin 10mg was	F 281	and/or Staff Development Coordinator on the requirements for compliance with F281 with emphasis on the protocol for the timely processing of physician and nurse practitioner orders. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Assistant Director of Nursing will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring 3 different resident□s charts to ensure the timely and complete processing of orders 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	

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 09/22/2017

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	Continued From page 8	F 281		

documented as administered at 8:00 PM during the period of 09/15/17 through 09/19/17. This MAR also revealed Risperidone 0.25mg twice a day was documented as administered at 8:00 AM and 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed that vital signs ordered done twice a day were not started until 4:00 PM on 09/18/17.

Another Nurse Practitioner note for Resident #165 dated 09/18/17 revealed the visit was a follow up after medications were decreased on 09/15/17. The note documented that Risperidone and Melatonin were to be decreased over the weekend after she wrote an order on 09/15/17 in response to low blood pressure and a hospital visit on 09/14/17. The note further documented the resident appeared "just as lethargic on exam" with no change reported by nursing staff. The note further documented she went to review blood pressure and found the entire page of orders written on 09/15/17 were not in "the system" even though they were signed off. The note documented the ADON, Unit Manager and hall nurse as being notified and morning medications as held.

Telephone interview with a family member of Resident #165 on 09/20/17 at 9:33 AM revealed the resident saw the Cardiologist the previous week and one of his medications was stopped, but she could not remember which one.

Interview with the Nurse Practitioner on 09/21/17 at 11:20 AM revealed Resident #165 had seen the Cardiologist on 09/14/17, who called her to report lethargy and hypotension, with a recommendation to stop Imdur. The resident was sent to the ED from the Cardiologist's office and

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 09/22/2017

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	Continued From page 9	F 281		

was "in the 70's" [systolic blood pressure], with the report that the resident looked so much different from the last time he was seen by the Cardiologist four months prior. She stated the resident returned to the facility the evening of 09/14/17 and she checked on him on Friday 09/15/17. She stated she was told by a nurse there was no hospital order to stop Imdur, so she went ahead and wrote the order, as well as wrote an order to take the resident off Risperidone in the morning and an order to decrease Melatonin. She stated she checked on the resident on 09/20/17 and staff still had not decreased Melatonin, which the Unit Manager said she would do. She stated that continuing to take Imdur could have sent the resident sent back to the hospital and the Cardiologist thought the blood pressure was so low due to Imdur. She stated that was the reason why she also ordered vital signs twice a day for a week to make sure the medication changes were working. She stated she expected staff to follow provider orders in a timely manner and to call her if there were complications, but they needed to follow the orders. She stated that with the resident having dementia he was unable to report symptoms so following vital signs was very important. She stated she brought her concerns to the ADON on 09/18/17 because she would take action and she also informed the Director of Nursing (DON) on 09/19/17. She stated when she wrote orders she put them on a cart and would bring them to a Unit Manger if before 3:00 PM, or would leave them with the Evening Supervisor if after 3:00 PM. She stated the page of orders would be flipped over and flagged and left in the resident's chart. She stated she could not remember if the orders and chart for Resident #165 were left with a specific person at the nursing station.

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 09/22/2017

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	Continued From page 10	F 281		

Interview with Nurse #3 on 09/22/17 at 9:23 AM revealed that when physicians and nurse practitioners wrote new orders they sometimes gave them to one of the Unit Managers at the main nursing station or they sometimes gave them to her directly. She stated she sometimes put these orders in the computer. She stated if a physician or nurse practitioner saw a resident they might verbalize orders to her at that time, but she would not put the orders into the computer until they were written down. She stated sometimes she would help the Unit Managers with reviewing orders if they were busy processing newly admitted residents, at which time they would bring her the chart with the orders if they wanted her to do this. She stated that once the orders were placed in the computer the Pharmacy would get the orders for processing after 15 minutes, and if the order was written "STAT" she would call the Pharmacy directly, or see if they had the medication in the computerized dispensing system in the medication room. She stated she did not remember anyone handing her orders on 09/15/17 for Resident #165 and she did not know there were any new orders for him. She stated when she assumed care the morning of 09/15/17 the off-going nurse mentioned he went to the Doctor's office that Thursday, 09/14/17, but she did not recall anything specific and she did recall them mentioning he had gone to the hospital. She stated she did not remember him having problems with low blood pressure, which she would know about as she checked his blood pressure before giving him his blood pressure medication, and she did not remember it being low that particular week. She stated if an order was discontinued it would be indicated as such in

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 09/22/2017

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	Continued From page 11	F 281		

the MAR, it would be clear that it was discontinued and there would be no place in the MAR to sign off if giving it.

Nurse #3 further stated that vital signs were documented in the computerized record and if they were ordered to be done twice a day, the order should be put on the MAR, timed for the day and evening shift, or the nurse would not know about it. She stated that by being placed on the MAR the order would "pop" up and staff would know to get the vital signs. She stated she did not know about the order change for the risperidone either. She stated that based on her review of the vital signs in the computerized record, they appeared to have been done and documented as twice a day only on 09/15/17, with no vital signs recorded on 09/16/17, one set recorded on each day from 09/17/17 through 9/20/17 and as being done three times on 09/21/17. She stated the vital signs that were recorded revealed normal blood pressures.

Interview with Unit Manager #1 and Unit Manager #2 on 09/22/17 at 9:54 AM revealed physicians and nurse practitioners brought to a particular Unit Manager new orders, depending on what hallway the resident resided and as assigned to the Unit Managers. They stated that once orders were entered into the computer, the yellow copy of the printed orders was given to the nurses, who were expected to double check the accuracy of the orders. They stated if lots of orders were written and they could not review them all before the end of their shift, those left remaining for review were given to the Evening Supervisor. They stated sometimes orders were handed to them, sometimes they were put in the record rack and sometimes they were laid on the desk of the

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 09/22/2017

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	Continued From page 12	F 281		

nursing station. They stated physicians and nurse practitioners would verbalize "STAT" orders and bring them to their attention immediately. They stated orders left in records on a cart were flagged, as indicated by turning the page of orders up so they would stick out of the record. Unit Manager #1 stated she did not remember orders for Resident #165 coming to her attention by the Nurse Practitioner until Monday 09/18/17, at which time she saw they were not in the computer and she put them in the computer (Unit Manager #2 did not work that particular day). They stated that on weekends when they did not work, the weekend nurses reviewed orders and put them in the computer. Unit Manager #1 stated that any missed orders should have been picked up during chart checks. They stated that when they saw handwritten orders with initials next to them, they assumed the orders had been reviewed and processed. They stated the Evening Supervisor should have picked up the orders, but they could not say what was going on. They stated that once discontinuation orders were put into the computer, the order would come off the MAR.

Interview with the ADON and the DON on 09/22/17 at 11:46 AM revealed the Unit Managers verified all orders during the week and at other times the Evening Supervisor or Weekend Supervisor would do it as well as a second check for the Unit Managers. They stated they thought the current order process was "pretty tight." They stated that what they knew about Resident #165's orders was that there were two sheets of orders, of which one sheet was reviewed and entered into the computer by the PM supervisor. They stated medication error reports were completed. They stated sometimes the Nurse Practitioner

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 09/22/2017

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	Continued From page 13	F 281		

would not have a resident's hard chart and would lay order sheets down at the computer at the nursing station. They stated it was important for orders to be transcribed and followed. They stated it was the responsibility of the Evening Supervisor to make sure any orders left on the cart by the Nurse Practitioner were reviewed. They stated vital signs should have been done for Resident #165 as ordered.

Telephone interview with the Evening Supervisor on 09/22/17 at 12:25 PM revealed that when she started her shift she assumed responsibility to review orders noted reviewed by the Unit Managers. She stated some physicians and nurse practitioners could be late to round on residents and would write orders on the PM shift, which she would review before she went home at the end of her shift. She stated that sometimes orders might be written on two pages and the pages would stick together, which was something she checked for. She stated that other times physicians and nurse practitioners would write orders, but rather than place them in the hard chart they would instead hand them to staff. She stated she did not recall taking off any orders for Resident #165 on 09/15/17, although it might have been possible.

Telephone interview with the nurse of the Cardiologist on 09/22/17 at 12:55 PM revealed the Cardiologist was seeing patients but she would notify the Cardiologist and get them to write a statement for the record. She stated Imdur should not be given to someone who is hypotensive.

Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the

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 09/22/2017

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	Continued From page 14 resident had intermittent hypotension and was on Imdur. The statement further documented "This medication should be held if he is hypotensive. I recommend holding the medication for systolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given Imdur, it will aggravate hypotension." Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 record review, observation and staff interviews, the facility failed to follow care plan interventions for fall prevention which included 2 fall mats for one (1) of one (1) fall risk resident (Resident #69). Resident #69 was admitted to the facility on 02/23/17 with diagnoses including muscle weakness, anxiety disorder, insomnia, bi-polar disorder, abnormalities of gait and mobility and muscle wasting with weakening. Review of Resident #69's most recent comprehensive Minimum Data Set (MDS) dated	F 282	F282 (D) Services by Qualified Persons/Per Care Plan How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The process that led to the deficient practice is as follows: The Care plan reflected the appropriate measure of 2 fall mats, the RCS, Unit Manager, and Hall Nurse did not communicate that resident was short 1	10/20/17

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 09/22/2017

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 282	Continued From page 15 08/01/17 revealed resident to be unable to make important decisions in his life. Resident #69 was assessed for most activities of daily living as requiring extensive assistance with two person assist. He was also assessed as always incontinent of bladder and bowel and he was not on a scheduled toileting program. Record review of Resident #69's care plan dated 08/10/17 revealed a care plan area for fall prevention. Interventions included an addition of a bolster mattress, fall mats x2, anti-slip surface placed on resident's wheelchair and use of an alarm while resident was in bed or in his wheelchair. Electronic record review of the entered Nurse's progress notes revealed multiple documented instances of resident attempting to transfer out of bed on his own. Some attempts resulted in documented falls. Observation on 09/20/17 at 11:23 AM revealed resident attempting to get out of bed on his own. Further observation revealed only one fall mat on the floor to the right of resident's bed (as he is lying in it). Observation on 09/20/17 at 12:41 PM revealed only one fall mat in resident's room. Observation on 09/21/17 at 9:3 AM continued to reveal only one fall mat in resident's room. Interview with nursing assistant (NA) #1 on 09/21/17 at 1:42 PM reported Resident #69 was a fall risk and was care planned with interventions in place to assist with preventing falls. He stated resident had anti-slip padding on his wheelchair,	F 282	matt. On 9/22/17 , 2 fall mats were placed at Resident #69s bedside. On 9/22/17 , NA #1, the hall nurse, the RCS (CNA□s) and the unit manager received a Teachable Moment on the importance of ensuring 2 fall mats are in place for Resident #1. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/22/17 , an audit was completed by, ADON , to ensure other resident□s fall interventions were in place per the plan of care. Any identified issues were immediately corrected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/22/17 + 10/4/17 , licensed nurses, and C.N.A.□s were re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F282 with emphasis on ensuring fall mats are in place per the care planned intervention. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Unit Managers will randomly monitor corrective actions to ensure the	

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 09/22/2017

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 282	Continued From page 16 a fall mat by his bed, bed rails and a scoop mattress as a few of the interventions that were in place. Interview with the hall nurse on 09/21/17 at 1:35 PM revealed Resident #69 was a fall risk and had a diagnosis of dementia with behaviors that were, at times, directed towards others. She stated Resident #69 frequently attempted to transfer himself from the bed and had frequent falls from doing so. She continued stating when Resident #69 first was admitted to the facility, the family had hired a private sitter to try and prevent falls to no avail. The nurse informed that the resident had two fall mats while he was on the 100 Hall but since he moved to the 600 Hall, only one fall mat had been placed in his room. She stated she was unsure if someone had changed the care plan. An interview with NA #2 on 09/21/17 at 2:26 PM revealed she was aware Resident #69 was a fall risk. She reported there being multiple interventions in place including a fall mat among others. She stated she and the other NAs are informed daily if changes to a resident's care plan are made. She stated she is informed on the Resident Care Specialist Assignment Sheet that were provided to all NAs. She further explained Resident #69 has only ever had one fall mat located to the right of his bed. Review of the Resident Care Specialist Assignment Sheet on 09/21/17 at 2:33 PM revealed under Accident Prevention/ Pressure Ulcer Prevention that Resident #69 was to have a pressure alarm to bed and chair, fall matt x 2, scoop mattress, green glide to wheelchair and hi-lo (bed).	F 282	effectiveness of these actions by randomly monitoring 3 different residents to ensure fall interventions are in place per the plan of care 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	

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 09/22/2017

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 282	Continued From page 17 An interview with the Minimum Data Set (MDS) coordinator on 09/21/17 at 2:18 PM revealed she and two other MDS coordinators were responsible for updating resident care plans. She reported resident care plans were reviewed after every fall for possible intervention changes. She continued, stating if changes were requested by administration, she or one of the other MDS coordinators would process the requested change. She reported to her knowledge there had been no requested changes to Resident #69's care plan in regards to removing a fall mat. An interview with the Assistant Director of Nursing on 09/21/17 at 2:46 PM revealed she expected every care plan to be followed as written and if the care plan called for two fall mats, that two fall mats were placed at Resident #69's bedside. An interview with the Director of Nursing on 09/21/17 at 3:17 PM revealed she expected that care plans were followed as written. An interview with the Administrator on 09/22/17 at 11:23 PM revealed she expected that care plans were followed as directed until changed.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life 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	F 309		10/20/17

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 09/22/2017

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 309	Continued From page 18 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 observation, record review, family interview, staff interviews and provider interviews, the facility failed to implement for three days provider order changes to discontinue an antihypertensive medication, increase vital signs monitoring frequency, decrease the dosage of a non-narcotic sleep aid and to decrease the frequency of administration of an antipsychotic medication for a resident with known sedation and low blood pressure (Resident #165), who was 1 of 4 residents reviewed for well-being.	F 309	F309 (D) Provide Care/Services for Highest Well Being How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Process that lead to deficiency practice: Nurse that should have processed the	

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 09/22/2017

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 309	Continued From page 19 The findings are: Resident #165 was admitted to the facility on 06/20/17 with diagnoses including history of a cerebral infarct, dementia, atherosclerosis, hypertension and gait abnormality. Review of a medication order for Resident #165 dated 06/20/17 revealed the antihypertensive medication Imdur 24 hour extended release, 15mg tablet, one table at bedtime. Review of Resident #165's admission Minimum Data Set (MDS) assessment dated 06/27/17 revealed he was severely cognitively impaired, displaying verbal behavior towards others and rejecting care for 1 to 3 days of the assessment period. The MDS noted the resident with a history of a fall without injury before his admission to the facility and as receiving both antipsychotic and antidepressant medications for the full 7 day assessment period. Review of Resident #165's Care Area Assessment (CAA) revealed the resident to have vascular dementia with known psychosis, which due to use of psychotropic medications and the risk of adverse reactions would be addressed in the resident's care plan. Review of Resident #165's care plan dated 07/06/17 included the problems of resistive to care related to adjustment to nursing home care, dementia, a new environment and wandering, with numerous non-medication interventions noted but no mention of psychoactive medication use. The problem of being at risk for falls documented staff to observe ordered medications	F 309	order was distracted at busy nurses station. Third shift nurses did not check charts for new orders missed. On 9/18/17, orders for Resident #165 were processed to include the following; discontinuation of Imdur, dose reduction for Melatonin, frequency reduction for Risperdone and increase in vital sign monitoring frequency. On 9/18/17 , Unit Manager #1 received a Teachable Moment on the expectation regarding timely processing of orders. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/18/17, an audit was completed by, Unit Managers , to ensure no other orders were missed and/or outstanding. No other issues were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 9/18/17 + 10/4/17, licensed nurses were re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F309 with emphasis on the protocol for the timely processing of physician and nurse practitioner orders. How the corrective action(s) will be	

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 09/22/2017

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 309	Continued From page 20 for side effects and effectiveness. Review of an order for Resident #165 dated 09/01/17 directed an additional 240cc of fluids with each meal tray in addition to what is served, and to hold antihypertensive medications Metoprolol and Cozaar due to low blood pressure. Another order dated 09/03/17 directed holding Cozaar until Tuesday (09/05/17) until the Nurse Practitioner followed up. Review of a Nurse Practitioner note for Resident #165 dated 09/05/17 revealed that due to hypotension (low blood pressure) Cozaar would be discontinued, the Metoprolol dosage would be lowered and follow up would be made with Cardiology as the resident was on Imdur. Review of an order dated 09/05/17 directed the resident to have made for him a follow up appointment with the Cardiologist related to Imdur, hypotension, fatigue, and coronary artery disease. Review of an Emergency Department (ED) report dated 09/14/17 revealed Resident #165 arrived from a Cardiology clinic for low blood pressure in the 70s (systolic) over 50s (diastolic) with family noting increased somnolence for several days. The Cardiologist was reported to have concerns with overmedication and the resident presented with no other signs or symptoms. The report stated his blood pressure improved since his arrival with the hospitalist team speaking to the Cardiologist. A recommendation was made to hold Imdur and to follow up as needed. A handwritten note by the Nurse Practitioner on this report documented that Imdur was not held when the resident returned to the facility. Review of a Nurse Practitioner note for Resident	F 309	monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Evening Supervisor will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring 3 different resident□s charts to ensure the timely and complete processing of orders 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	

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 09/22/2017

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 309	Continued From page 21	F 309		

#165 dated 09/15/17 revealed the visit was a follow up after the resident's ED evaluation on 09/14/17. The note documented the resident as having hypotension and as being sent to the hospital from the Cardiologist's office with "BP in 70s [systolic]." The note further documented the Cardiologist had called the Nurse Practitioner with an update and the Assistant Director of Nursing (ADON) also being notified. It was documented that per the Cardiologist, the Imdur was to be discontinued, vital signs checked twice a day for a week and to see if there was a need to further decrease the Metoprolol. The resident was noted to also be on Risperidone twice a day and notification would be made to the Psychiatrist to decrease the Risperidone.

Review of orders for Resident #165 dated 09/15/17 included the following: discontinue Imdur, decrease Melatonin to 5mg dose at bedtime, discontinue Risperidone 0.25mg twice a day and start Risperidone 0.25mg at bedtime and obtain vital signs twice a day for one week then to have the Nurse Practitioner review them, related to hypotension on 9/14/17.

Review of the Medication Administration Record (MAR) for Resident #165 for September, 2017 revealed Imdur extended release 24 hour, 15mg was documented as administered at 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed Melatonin 10mg was documented as administered at 8:00 PM during the period of 09/15/17 through 09/19/17. This MAR also revealed Risperidone 0.25mg twice a day was documented as administered at 8:00 AM and 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed that vital signs ordered done twice a day were not

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 09/22/2017

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 309	Continued From page 22	F 309		

started until 4:00 PM on 09/18/18.

Review of another Nurse Practitioner note for Resident #165 dated 09/18/17 revealed the visit was a follow up after medications were decreased on 09/15/17. The note documented that Risperidone and Melatonin were to be decreased over the weekend after she wrote an order on 09/15/17 in response to low blood pressure and a hospital visit on 09/14/17. The note further documented the resident appeared "just as lethargic on exam" with no change reported by nursing staff. The note further documented she went to review blood pressure and found the entire page of orders written on 09/15/17 were not in "the system" even though they were signed off. The note documented the ADON, Unit Manager and hall nurse as being notified and morning medications as held.

Observation of Resident #165 dated 09/19/17 at 4:19 PM revealed him to be in his wheelchair in the hallway in no distress, having a calm affect but providing no verbal response to a greeting.

Interview with Nurse #2 on 09/20/17 at 5:29 AM revealed she was not familiar with any medication concerns regarding Resident #165 as no medications were passed to him on night shift.

Telephone interview with a family member of Resident #165 on 09/20/17 at 9:33 AM revealed he saw the Cardiologist the previous week and one of his medications were stopped, but she could not remember which one.

Interview with the Nurse Practitioner on 09/21/17 at 11:20 AM revealed Resident #165 had seen the Cardiologist on 09/14/17, who called her to

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 09/22/2017

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 309	Continued From page 23	F 309		

report lethargy and hypotension, with a recommendation to stop Imdur and to decrease Cozaar. The resident was sent to the ED from the Cardiologist's office and was "in the 70's" [systolic blood pressure], with the report that the resident looked so much different from the last time he was seen by the Cardiologist four months prior. She stated the resident returned to the facility the evening of 09/14/17 and she checked on him on Friday 09/15/17. She stated she was told by a nurse there was no hospital order to stop Imdur, so she went ahead and wrote the order, as well as wrote an order to take the resident off Risperidone in the morning and an order to decrease Melatonin. She stated she checked on the resident on 09/20/17 and staff still had not decreased Melatonin, which the Unit Manager said she would do. She stated that the resident continuing to take Imdur could have sent him back to the hospital and the Cardiologist thought the blood pressure was so low due to Imdur. She stated that was the reason why she also ordered vital signs twice a day for a week to make sure the medication changes were working. She stated she expected staff to follow provider orders in a timely manner and to call her if there were complications, but they needed to follow the orders. She stated that with the resident having dementia he was unable to report symptoms so following vital signs was very important. She stated she brought her concerns to the ADON on 09/18/17 because she would take action and she also informed the Director of Nursing (DON) on 09/19/17.

Interview with Nurse #3 on 09/22/17 at 9:23 AM revealed she did not remember anyone handing her orders on 09/15/17 for Resident #165 and she did not know there were any new orders for

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 09/22/2017

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 309	Continued From page 24	F 309		

him. She stated when she assumed care the morning of 09/15/17 the off-going nurse mentioned he went to the doctor's office that Thursday 09/14/17, but she did not recall anything specific and she did recall them mentioning he had gone to the hospital. She stated she did not remember him having problems with low blood pressure, which she would know about as she checked his blood pressure before giving him his blood pressure medication, and she did not remember it being low that particular week. She stated if an order was discontinued it would be indicated as such in the MAR, it would be clear that it was discontinued and there would be no place in the MAR to sign off if giving it.

Nurse #3 further stated that vital signs were documented in the computerized record and if they were ordered to be done twice a day, the order should be put on the MAR, timed for the day and evening shift, or the nurse would not know about it. She stated that by being placed on the MAR the order would "pop" up and staff would know to get the vital signs. She stated she did not know about the order change for the risperidone either. She stated that based on her review of the vital signs in the computerized record, they appeared to have been done and documented as twice a day only on 09/15/17, with no vital signs recorded on 09/16/17, one set recorded on each day from 09/17/17 through 9/20/17 and as being done three times on 09/21/17.

Interview with Unit Manager #1 and Unit Manager #2 on 09/22/17 at 9:54 AM revealed Unit Manager #1 stateing she did not remember orders for Resident #165 coming to her attention

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 09/22/2017

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 309	Continued From page 25	F 309		

by the Nurse Practitioner until Monday 09/18/17, at which time she saw they were not in the computer and she put them in the computer (Unit Manager #2 did not work that particular day). Unit Manager #1 stated that any missed orders should have been picked up during chart checks. They stated the PM Supervisor should have picked up the orders, but they could not say what was going on. They stated that once discontinuation orders were put into the computer, the order would come off the MAR.

Interview with the ADON and the DON on 09/22/17 at 11:46 AM revealed what they knew about Resident #165's orders was that there were two sheets of orders, of which one sheet was reviewed and entered into the computer by the PM supervisor. They stated medication error reports were completed. They stated it was important for orders to be transcribed and followed. They stated it was the responsibility of the PM Supervisor to make sure any orders left on the cart by the Nurse Practitioner were reviewed. They stated vital signs should have been done for Resident #165 as ordered.

Telephone interview with the PM Supervisor on 09/22/17 at 12:25 PM revealed that when she started her shift she assumed responsibility to review orders noted reviewed by the Unit Managers. She stated she did not recall taking off any orders for Resident #165 on 09/15/17, although it might have been possible.

Telephone interview with the nurse of the Cardiologist on 09/22/17 at 12:55 PM revealed the Cardiologist was seeing patients but she would notify the Cardiologist and get them to write a statement for the record. She stated Imdur

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 09/22/2017

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 309	Continued From page 26 should not be given to someone who is hypotensive. Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident had intermittent hypotension and was on Imdur. The statement further documented "This medication should be held if he is hypotensive. I recommend holding the medication for systolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given Imdur, it will aggravate hypotension." Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). The findings include: Resident #166 was admitted to the facility on 08/09/17 with diagnoses of non-Alzheimer's dementia, history of falls and muscle weakness. Review of the significant change Minimum Data	F 312	F312 (D) ADL Care Provided for Dependent Residents How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Process that lead to deficient practice is as follows: The shower schedule had not been followed per assignment and RCS did not communicate this to the Nurse. On 9/22/17 , a shower was offered and	10/20/17

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 09/22/2017

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 312	Continued From page 27 Set dated 09/07/17 revealed Resident #166 was cognitively intact and required extensive assistance with bathing. Review of the care plan dated 09/20/17 revealed Resident #166 had an activity of daily living (ADL) self-care performance deficit related to extensive up to total assist with ADL and at risk for further decline related to chronic diagnoses/disease process. The goal was for Resident #166 to maintain current level of function through the review date. The interventions included: bathing/showering 2 times per week and as needed, check nail length and trim and clean on bath day and as needed. Review of the facility shower schedules from 08/09/17 through 09/21/17 revealed Resident #166's scheduled shower days were Wednesday and Saturday. The schedules revealed Resident #166 received showers on the following dates: 08/09/17 -Wednesday, 08/15/17 - Tuesday, 08/23/17 - Wednesday, 08/30/17 - Wednesday, 09/13/17 - Wednesday, and 09/20/17 - Wednesday. An interview conducted on 09/18/17 at 11:25 AM with Resident #166 revealed he was not receiving 2 showers a week. He stated he had only been getting 1 shower a week and some weeks only a bed bath and he wanted 2 showers a week. An interview conducted on 09/20/17 at 10:56 AM with Nurse Aide (NA) #1 revealed she works on the 100 Hall with Resident #166 on the 7:00 AM to 7:00 PM shift. She stated there were many days she couldn't get all of the scheduled showers done because she was the only NA on the hall. She stated there is only 1 NA scheduled	F 312	provided to Resident #166. On 9/22/17 , NA #1 and NA #2 received a Teachable Moment on the expectation for completion of showers as scheduled as well as the protocol for communicating incomplete tasks their direct supervisor. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/23/17 , shower schedules were reviewed to ensure residents scheduled to receive showers were offered and provided bathing per preference as scheduled. Any identified issues were corrected immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/4/17 , direct care and licensed nursing staff was re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F312 with emphasis on ensuring showers are being offered and are provided per facility shower schedule and PRN. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Unit Managers will randomly monitor corrective actions to ensure the	

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 09/22/2017

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 312	Continued From page 28 to work the 100 hall and it makes it very difficult to provide care and showers for residents. An interview conducted on 09/21/17 at 9:47 AM with NA #2 revealed he works all of the halls and all 3 shifts. He stated the hardest hall to work was the 100 hall because you were the only NA on the hall. He stated he made sure residents were clean and dry but did not always get the showers done due to staffing. An interview conducted on 09/22/17 at 8:43 AM with the Director of Nursing (DON) revealed depending on the resident census there were 1 to 2 NAs scheduled to work the 100 hall. She stated it was her expectation for all showers to be completed as scheduled and if they weren't able to be given the NA should report to the oncoming shift so they can give them. She stated she was not aware staff were having problems getting showers completed. An interview conducted on 09/22/17 at 10:54 AM with the Administrator revealed it was her expectation for residents to receive their showers as scheduled.	F 312	effectiveness of these actions by randomly monitoring 3 resident□s shower schedules to ensure showers are being provided as scheduled 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Care Management to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family	F 333	F333 (D) Residents Free of Significant	10/20/17

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 09/22/2017

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 333	Continued From page 29 interview, staff interviews and provider interviews, the facility failed to (1)discontinue as ordered an antihypertensive medication, reduce the dosage for a non-narcotic sleep aid and reduce the frequency of administration of an antipsychotic medication for 3 days for Resident #165 with known sedation and low blood pressure and (2) failed to discontinue as ordered and for 11 days for Resident #30 a narcotic pain medication, for 2 of 6 residents reviewed for unnecessary medications. The findings are: 1. Resident #165 was admitted to the facility on 06/20/17 with diagnoses including history of a cerebral infarct, dementia, atherosclerosis, hypertension and gait abnormality. Review of a medication order for Resident #165 dated 06/20/17 revealed the antihypertensive medication Imdur 24 hour extended release, 15mg tablet, one table at bedtime. Review of Resident #165's admission Minimum Data Set (MDS) assessment dated 06/27/17 revealed he was severely cognitively impaired, had a history of a fall without injury before his admission to the facility and as receiving both antipsychotic and antidepressant medications for the full 7 day MDS assessment period. Review of Resident #165's Care Area Assessment (CAA) revealed the resident to have vascular dementia with known psychosis, which due to use of psychotropic medications and the risk of adverse reactions would be addressed in the resident's care plan.	F 333	Med Errors How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Process that lead to deficient practice is as follows: For #1. Nurse that should have processed the order was distracted at busy nurses station. Third shift nurses did not check charts for new orders missed. #2. Nurse failed to clarify order with the potential for error and or miscommunication due to ambiguity. 1. On 9/18/17 , orders for Resident #165 were processed to include the following; discontinuation of Imdur, dose reduction for Melatonin, frequency reduction for Risperdone and increase in vital sign monitoring frequency. On 9/18/17, Unit Manager #1 received a Teachable Moment on the expectation regarding timely processing of orders. 2. On 9/22/17, Resident #30s narcotic pain medication was discontinued as ordered. On 9/22/17, Nurse #1 and Unit Managers #1 and #2 received a Teachable Moment on the need to clarify orders with the potential for error and/or miscommunication due to ambiguity. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/22/17, an audit was completed by, DON, ADON, and Unit Managers to	

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 09/22/2017

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 333	Continued From page 30 Review of Resident #165's care plan dated 07/06/17 included the problems of resistive to care related to adjustment to nursing home care, dementia, a new environment and wandering, with numerous non-medication interventions noted but no mention of psychoactive medication use. The problem of being at risk for falls documented staff to observe ordered medications for side effects and effectiveness. Review of a Nurse Practitioner note for Resident #165 dated 09/05/17 revealed that due to hypotension (low blood pressure) Cozaar would be discontinued, the Metoprolol dosage would be lowered and follow up would be made with Cardiology as the resident was on Imdur. Review of an order dated 09/05/17 directed the resident to have made for him a follow up appointment with the Cardiologist related to Imdur, hypotension, fatigue, and coronary artery disease. Review of an Emergency Department (ED) report dated 09/14/17 revealed Resident #165 arrived from a Cardiology clinic for low blood pressure in the 70s (systolic) over 50s (diastolic) with family noting increased somnolence for several days. The Cardiologist was reported to have concerns with overmedication and the resident presented with no other signs or symptoms. The report stated his blood pressure improved since his arrival with the hospitalist team speaking to the Cardiologist. A recommendation was made to hold Imdur and to follow up as needed. A handwritten note by the Nurse Practitioner on this report documented that Imdur was not held when the resident returned to the facility. Review of a Nurse Practitioner note for Resident #165 dated 09/15/17 revealed the visit was a	F 333	ensure no other orders were missed and/or outstanding. No other issues were identified. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/4/17, licensed nurses were re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F333 with emphasis on the protocol for the timely processing of physician and nurse practitioner orders. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Staff Development Coordinator will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring 3 different resident□s charts to ensure the timely and complete processing of orders 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews.	

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 09/22/2017

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 333	Continued From page 31	F 333	Date of Compliance: 10/20/2017	

follow up after the resident's ED evaluation on 09/14/17. The note documented the resident as having hypotension and as being sent to the hospital from the Cardiologist's office with "BP in 70s [systolic]." The note further documented the Cardiologist had called the Nurse Practitioner with an update and the Assistant Director of Nursing (ADON) also being notified. It was documented that per the Cardiologist, the Imdur was to be discontinued, vital signs checked twice a day for a week and to see if there was a need to further decrease the Metoprolol. The resident was noted to also be on Risperidone twice a day and notification would be made to the Psychiatrist to decrease the Risperidone.

Review of orders for Resident #165 dated 09/15/17 included the following: discontinue Imdur, decrease Melatonin to 5mg dose at bedtime, discontinue Risperidone 0.25mg twice a day and start Risperidone 0.25mg at bedtime and obtain vital signs twice a day for one week then to have the Nurse Practitioner review them, related to hypotension on 9/14/17.

Review of the Medication Administration Record (MAR) for Resident #165 for September, 2017 revealed Imdur extended release 24 hour, 15mg was documented as administered at 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed Melatonin 10mg was documented as administered at 8:00 PM during the period of 09/15/17 through 09/19/17. This MAR also revealed Risperidone 0.25mg twice a day was documented as administered at 8:00 AM and 8:00 PM during the period of 09/15/17 through 09/17/17. This MAR also revealed that vital signs ordered done twice a day were not started until 4:00 PM on 09/18/18.

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 09/22/2017

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 333	Continued From page 32	F 333		

Review of another Nurse Practitioner note for Resident #165 dated 09/18/17 revealed the visit was a follow up after medications were decreased on 09/15/17. The note documented that Risperidone and Melatonin were to be decreased over the weekend after she wrote an order on 09/15/17 in response to low blood pressure and a hospital visit on 09/14/17. The note further documented the resident appeared "just as lethargic on exam" with no change reported by nursing staff. The note further documented she went to review blood pressure and found the entire page of orders written on 09/15/17 were not in "the system" even though they were signed off. The note documented the ADON, Unit Manager and hall nurse as being notified and morning medications as held.

Observation of Resident #165 dated 09/19/17 at 4:19 PM revealed him to be in his wheelchair in the hallway in no distress, having a calm affect but providing no verbal response to a greeting.

Interview with Nurse #2 on 09/20/17 at 5:29 AM revealed she was not familiar with any medication concerns regarding Resident #165 as no medications were passed to him on night shift.

Telephone interview with a family member of Resident #165 on 09/20/17 at 9:33 AM revealed he saw the Cardiologist the previous week and one of his medications were stopped, but she could not remember which one.

Interview with the Nurse Practitioner on 09/21/17 at 11:20 AM revealed Resident #165 had seen the Cardiologist on 09/14/17, who called her to report lethargy and hypotension, with a

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 09/22/2017

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 333	Continued From page 33	F 333		

recommendation to stop Imdur and to decrease Cozaar. The resident was sent to the ED from the Cardiologist's office and was "in the 70's" [systolic blood pressure], with the report that the resident looked so much different from the last time he was seen by the Cardiologist four months prior. She stated the resident returned to the facility the evening of 09/14/17 and she checked on him on Friday 09/15/17. She stated she was told by a nurse there was no hospital order to stop Imdur, so she went ahead and wrote the order, as well as wrote an order to take the resident off Risperidone in the morning and an order to decrease Melatonin. She stated she checked on the resident on 09/20/17 and staff still had not decreased Melatonin, which the Unit Manager said she would do. She stated that the resident continuing to take Imdur could have sent him back to the hospital and the Cardiologist thought the blood pressure was so low due to Imdur. She stated that was the reason why she also ordered vital signs twice a day for a week to make sure the medication changes were working. She stated she expected staff to follow provider orders in a timely manner and to call her if there were complications, but they needed to follow the orders. She stated that with the resident having dementia he was unable to report symptoms so following vital signs was very important. She stated she brought her concerns to the ADON on 09/18/17 because she would take action and she also informed the Director of Nursing (DON) on 09/19/17.

Interview with Nurse #3 on 09/22/17 at 9:23 AM revealed she did not remember anyone handing her orders on 09/15/17 for Resident #165 and she did not know there were any new orders for him. She stated when she assumed care the

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 09/22/2017

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 333	Continued From page 34	F 333		

morning of 09/15/17 the off-going nurse mentioned he went to the doctor's office that Thursday 09/14/17, but she did not recall anything specific and she did recall them mentioning he had gone to the hospital. She stated she did not remember him having problems with low blood pressure, which she would know about as she checked his blood pressure before giving him his blood pressure medication, and she did not remember it being low that particular week. She stated if an order was discontinued it would be indicated as such in the MAR, it would be clear that it was discontinued and there would be no place in the MAR to sign off if giving it.

Interview with Unit Manager #1 and Unit Manager #2 on 09/22/17 at 9:54 AM revealed Unit Manager #1 stating she did not remember orders for Resident #165 coming to her attention by the Nurse Practitioner until Monday 09/18/17, at which time she saw they were not in the computer and she put them in the computer (Unit Manager #2 did not work that particular day). Unit Manager #1 stated that any missed orders should have been picked up during chart checks. They stated the PM Supervisor should have picked up the orders, but they could not say what was going on. They stated that once discontinuation orders were put into the computer, the order would come off the MAR.

Interview with the ADON and the DON on 09/22/17 at 11:46 AM revealed what they knew about Resident #165's orders was that there were two sheets of orders, of which one sheet was reviewed and entered into the computer by the PM supervisor. They stated medication error reports were completed. They stated it was

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 09/22/2017

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 333	Continued From page 35	F 333		

important for orders to be transcribed and followed.

Telephone interview with the PM Supervisor on 09/22/17 at 12:25 PM revealed that when she started her shift she assumed responsibility to review orders noted reviewed by the Unit Managers. She stated she did not recall taking off any orders for Resident #165 on 09/15/17, although it might have been possible.

Telephone interview with the nurse of the Cardiologist on 09/22/17 at 12:55 PM revealed the Cardiologist was seeing patients but she would notify the Cardiologist and get them to write a statement for the record. She stated Imdur should not be given to someone who is hypotensive.

Review of a signed statement by the Cardiologist for Resident #165 dated 09/22/17 revealed the resident had intermittent hypotension and was on Imdur. The statement further documented "This medication should be held if he is hypotensive. I recommend holding the medication for systolic blood pressure less than 100 mmHg [millimeters of mercury]. If he is given Imdur, it will aggravate hypotension."

Interview with the Administrator on 09/22/17 at 12:56 PM revealed she expected new orders to be processed and followed.

2. Resident #30 was admitted to the facility on 09/08/17 with diagnoses of non-Alzheimer's dementia, Parkinson's disease, and anemia.

Review of the significant change Minimum Data

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 09/22/2017

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 333	Continued From page 36	F 333		

Set (MDS) dated 02/06/17 revealed Resident #30 was cognitively intact and could make his needs known.

Review of the physician orders dated 09/08/17 revealed an order was written to discontinue Norco, a pain medication, when current supply exhausted.

Review of the Medication Administration Record from 09/08/17 through 09/21/17 revealed Resident #30 received Norco on 09/09/17 at 9:00 PM, which was the last dose from medication card in the medication cart. Doses given from the medication card received in facility on 09/11/17 were - 09/11/17 at 8:52 PM, 09/12/17 at 8:45 PM, 09/13/17 at 8:39 PM, 09/14/17 at 8:23 PM, 09/16/17 at 1:46 PM, 09/16/17 at 9:10 PM, 09/17/17 at 1:47 PM, 09/17/17 at 4:20 PM, 09/17/17 at 8:55 PM, 09/19/17 at 9:00 PM, 09/20/17 at 9:38 AM, 09/20/17 at 8:20 PM and 09/21/17 at 12:04 PM.

An interview conducted on 09/21/17 at 4:20 PM with the facility Nurse Practitioner (NP) revealed she wrote an order on 09/08/17 to discontinue Resident #30's Norco when the supply was exhausted. She stated she spoke to the nurse before she wrote the order to ask her how many Norco tablets were remaining and was told he had two tablets left. The NP stated it was her intention for the Norco to be discontinued after the 2 doses were given. She stated she had spoken to the resident about his pain and he informed her he did not have pain but took the Norco to help him sleep and that is why she discontinued the medication. The NP further stated she was not aware there was an order at the pharmacy for a refill of the Norco and had she

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 09/22/2017

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 333	Continued From page 37 been aware she would have written the order to discontinue the Norco after the last 2 doses were given. An interview conducted on 09/22/17 at 9:55 AM with Unit Manager #1 and Unit Manager #2 revealed they would have expected the Norco for Resident #30 to be discontinued after the last dose on the card was given per the NP's order on 09/08/17. They further stated the order was not clearly written and the nurse should have clarified the order before reordering the Norco from the pharmacy on 09/11/17. An interview conducted on 09/22/17 at 12:06 with the Director of Nursing revealed it was her expectation for order's to be followed as written. She stated the order written on 09/08/17 to discontinued Resident #30's Norco should have been clarified with the NP as to discontinue when the last dose from the current card in the medication cart was given or discontinue when the prescription was out. She stated she interpreted the order as discontinue when the last dose was given from the current card in the medication cart. An interview conducted on 09/22/17 at 12:30 PM with Nurse #1 revealed she reordered Resident #30's Norco on 09/11/17 and she did not see the order to discontinue the Norco when the supply was deleted. She stated she should have reviewed the orders before reordering the Norco.	F 333		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services	F 353		10/20/17

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 09/22/2017

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 353	Continued From page 38 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 353		

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 09/22/2017

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 353	Continued From page 39 (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to provide sufficient nursing staff to complete scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). The findings include: Resident #166 was admitted to the facility on 08/09/17 with diagnoses of non-Alzheimer's dementia, history of falls and muscle weakness. Review of the significant change Minimum Data Set dated 09/07/17 revealed Resident #166 was cognitively intact and required extensive assistance with bathing. Review of the care plan dated 09/20/17 revealed Resident #166 had an activity of daily living (ADL) self-care performance deficit related to extensive up to total assist with ADL and at risk for further decline related to chronic diagnoses/disease process. The goal was for Resident #166 to maintain current level of function through the review date. The interventions included: bathing/showering 2 times per week and as needed, check nail length and trim and clean on bath day and as needed. Review of the facility shower schedules from 08/09/17 through 09/21/17 revealed Resident #166's scheduled shower days were Wednesday	F 353	F353 (D) Sufficient 24-HR Nursing Staff per Care Plans How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Process that lead to deficient practice is as follows: RCS did not communicate with Nurse that shower was not given, nor did they report to Charge Nurse. Nurse did not check to see if shower was given. Staffing pattern was not assessed and changed On 9/22/17 , a shower was offered and provided to Resident #166. On 9/22/17, NA #1 and NA #2 received a Teachable Moment on the expectation for completion of showers as scheduled as well as the protocol for communicating incomplete tasks their direct supervisor. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 9/23/17, staffing patterns were reviewed for effectiveness and shower schedules were reviewed to ensure residents scheduled to receive showers	

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 09/22/2017

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 353	Continued From page 40 and Saturday. The schedules revealed Resident #166 received showers on the following dates: 08/09/17 -Wednesday, 08/15/17 - Tuesday, 08/23/17 - Wednesday, 08/30/17 - Wednesday, 09/13/17 - Wednesday, and 09/20/17 - Wednesday. An interview conducted on 09/18/17 at 11:25 AM with Resident #166 revealed he was not receiving 2 showers a week. He stated he had only been getting 1 shower a week and some weeks only a bed bath and he wanted 2 showers a week. An interview conducted on 09/20/17 at 10:56 AM with Nurse Aide (NA) #1 revealed she works on the 100 Hall with Resident #166 on the 7:00 AM to 7:00 PM shift. She stated there were many days she couldn't get all of the scheduled showers done because she was the only NA on the hall. She stated there is only 1 NA scheduled to work the 100 hall and it makes it very difficult to provide care and showers for residents. An interview conducted on 09/21/17 at 9:47 AM with NA #2 revealed he works all of the halls and all 3 shifts. He stated the hardest hall to work was the 100 hall because you were the only NA on the hall. He stated he made sure residents were clean and dry but did not always get the showers done due to staffing. An interview conducted on 09/22/17 at 8:43 AM with the Director of Nursing (DON) revealed depending on the resident census there were 1 to 2 NAs scheduled to work the 100 hall during the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shift and 1 NA for the 100 and 600 Hall on the 11:00 PM to 7:00 AM shift. She stated it was her expectation for all showers to be completed as	F 353	were offered and provided bathing per preference as scheduled. Any identified issues were corrected immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/4/17 , direct care and licensed nursing staff was re-educated by the Director of Nursing and/or Staff Development Coordinator on the requirements for compliance with F353 with emphasis on effective staffing patterns and ensuring showers are being offered and are provided per facility shower schedule and PRN. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring effectiveness of staffing patterns for 3 different resident□s care to ensure showers are being provided as scheduled 3x/week X 4 weeks, then monthly X 2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director	

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 09/22/2017

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 353	Continued From page 41 scheduled and if they weren't able to be given the NA should report to the oncoming shift so they can give them. She stated she was unaware staff were having a difficult time completing showers on the 100 hall and felt like the building was adequately staffed. An interview conducted on 09/22/17 at 10:54 AM with the Administrator revealed it was her expectation for residents to receive their showers as scheduled. She stated the building was adequately staffed and if staff were having a difficult time completing their work they needed to inform the DON and herself.	F 353	of Care Management to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		10/20/17

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 09/22/2017

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 520	Continued From page 42 identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification and complaint survey of 08/05/16. This was for 5 deficiencies that were originally cited in August of 2016 and were subsequently recited on the current recertification and complaint survey of 09/22/17. The two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance Program. The findings included: These tags are cross referenced to:	F 520	F520 (D) QAA Committee-Membership/Meet Quarterly/Plans How will corrective action be accomplished for those residents found to have been affected by the deficient practice: On 10/16/17 , plans of correction were submitted for repeat citations F279, F282, F309, F312 and F353. On 10/16/17, the facility Administrator received education from the District Director of Clinical Services regarding implementation of a post survey performance improvement plan in order to eliminate and/or reduce the likelihood or repeat citations.	

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 09/22/2017

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 520	Continued From page 43 F 279: Comprehensive care plan: Based on observations, record review, family interview and staff interviews, the facility failed to include psychoactive medications in an individualized care plan for 1 of 6 residents reviewed for unnecessary medications (Resident #165). During the recertification survey of 08/05/16 the facility was cited at F279 for failing to develop a care plan for a foot wound for 1 of 4 residents reviewed for wounds (Resident #158). F 282: Services by qualified professional per care plan: Based on record review, observation and staff interviews, the facility failed to follow care plan interventions for fall prevention which included 2 fall mats for one (1) of one (1) fall risk resident (Resident #69). During the recertification survey of 08/05/16 the facility was cited at F282 for failing to follow the physician's orders as written for treatments, the care plans, and failed to complete wound care treatments for 1 of 3 sampled residents reviewed for dressing changes and wound care (Resident #56). F309: Care and Services: Based on observation, record review, family interview, staff interviews and provider interviews, the facility failed to implement for three days provider order changes to discontinue an antihypertensive medication, increase vital signs monitoring frequency, decrease the dosage of a non-narcotic sleep aid and to decrease the frequency of administration of an antipsychotic medication for a resident with known sedation and low blood pressure	F 520	How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: On 10/16/17 , audits were completed as per annual survey plans of correction to ensure no other residents were being affected by the respective deficient practice. Any identified issues were corrected immediately. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/16/17, the Administrator was re-educated by the District Director of Operations on the requirements for compliance with F520 and by the District Director of Clinical Services on the post survey performance improvement process with emphasis on implementation of monitoring strategies to reduce and/or eliminate the likelihood of repeat citations. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Administrator will randomly monitor corrective actions to ensure the effectiveness of these actions by monitoring audit findings of each of the October 2017 annual survey citations weekly X 4 weeks, monthly X 2 months and quarterly thereafter until compliance has been determined.	

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 09/22/2017

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 520	Continued From page 44 (Resident #165), who was 1 of 4 residents reviewed for well-being. During the recertification survey of 08/05/16 the facility was cited at F282 for failing to administer pain medication to a resident who had a below the knee amputation causing the resident to have unrelenting pain for 1 of 3 sampled residents reviewed for pain management. The facility also failed to follow a physician's order for wound care and dressing changes for 1 of 4 sampled residents reviewed for wound care (Resident #197 and #158). F312: Activities of daily living: Based on observations, record review and resident and staff interviews the facility failed to provide scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). During the recertification survey of 08/05/16 the facility was cited at F282 for failing to provide oral care and showers for 4 of 7 dependent sampled residents (Resident #1, #8, #45, and #109). F353: Sufficient nursing staff: Based on observations, record review and resident and staff interviews the facility failed to provide sufficient nursing staff to complete scheduled showers for 1 of 2 residents reviewed for activities of daily living (Resident #166). During the recertification survey of 08/05/16 the facility was cited at F282 for failing to provide sufficient nursing staff to meet the needs for residents in the areas of staff not meeting the	F 520	Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been achieved and the committee recommends quarterly oversight by the District Director of Clinical Services to maintain compliance when completing facility reviews. Date of Compliance: 10/20/2017	

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 09/22/2017

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 520	Continued From page 45 needs of the residents' showers and incontinence care (Residents #1, #45, #109). An interview with the Administrator on 09/22/17 at 1:18 PM revealed the facility followed the plan of correction and did all of the monitoring for the plan and thought they had resolved the issues from the citations in 08/05/17. She stated she could not say why the areas were re-cited in the current survey.	F 520		