STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 10/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to provide 5 doses of a medication to treat urinary incontinence for 1 of 3 residents with medications reviewed. (Resident #1) The findings included: Resident #1 was admitted to the facility 07/07/13 with diagnoses which included diabetes, heart failure and history of urinary tract infections. The latest Minimum Data Set dated 10/04/17 assessed Resident #1 as frequently incontinent of bladder. The current care plan for Resident #1 included a problem area initiated 12/21/16 which noted, Resident has actual elimination deficit related to bladder incontinence, bowel incontinence and risk of constipation. Review of a physician's progress note in the medical record of Resident #1 noted on 08/11/17 that Resident #1 was seen for several complaints	F 425	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provision of federal and state law." 1. On 10/18/17 orders were clarified with the physician for Resident #1 and a valid order was entered in to the electronic medical record by the Director of Nursing. On 10/17/17 the Director of Nursing received a Teachable Moment with the District Director of Clinical Services on the expectation regarding clarification of orders as necessary as well as expectations regarding Clinical Morning Meeting review of the PCC Order Listing Report and delegation of follow up	11/14/17

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

Electronically Signed | 11/08/2017

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F 425	Continued From page 1 including "urinary incontinence when she lays down." The physician ordered 5 milligrams of Oxybutynin (a medication used to treat symptoms of an overactive bladder) at bedtime to see if it would help with the urinary incontinence. Review of the 2017 October Medication Administration Record for Resident #1 noted 5 doses of the Oxybutynin were not administered to Resident #1 as ordered because the medication was not available. Nursing progress notes associated with the omission of the medication were written by two separate nurses and noted the medication was not given and was on order. On 10/17/17 at 10:44 AM in a phone conversation with the facility pharmacy they reported the last time Oxybutynin had been refilled was on 08/11/17 when a 30 day supply was sent to the facility. On 10/17/17 at 3:45 PM the Director of Nursing (DON) stated she explored the situation involving the Oxybutynin for Resident #1 and found a former nurse entered a discontinue order in the electronic system on 8/14/17 (when the nurse wrote a clarification order.) The DON stated the Oxybutynin was not supposed to be discontinued and the DON stated she verified this via a conversation with the physician of Resident #1. The DON stated the discontinuation only went to the pharmacy and the Oxybutynin remained on the Medication Administration Record for Resident #1. The DON stated when she spoke with the pharmacy they reported they never refilled the Oxybutynin (as requested by the facility) because they thought it had been discontinued. The DON stated the two nurses that noted the Oxybutynin was not available to be	F 425	regarding clarification of orders as necessary. On 11/2/17 and 11/6/17 nurses involved in documenting medication not available received a Teachable Moment with the DON regarding the medication ordering process and follow up. 2. On 11/1 - 11/4/17 a Medication Administration Audit was completed by the Director of Nursing to ensure no other medications were missed and/or not administered. No other issues were identified. 3. On 10/26/17 licensed nurses, including agency nurses, were re-educated by the Director of Nursing on the requirements for compliance with F425 with emphasis on the protocol for reordering medications, when to contact the pharmacy and follow-up on medications not available. Any new nurses and/or agency nurses will receive the same training. 4. The Unit Managers will randomly monitor corrective actions to ensure the effectiveness of these actions by randomly monitoring 3 different resident's Medication Administration Records biweekly x4 weeks and then monthly x2 months or until compliance has been determined. Findings will be reported at the monthly QAPI meeting until such time as substantial compliance has been	

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F 425	Continued From page 2 given to Resident #1 on 10/10/17, 10/11/17, 10/13/17, 10/14/17 and 10/16/17 were agency nurses and may not have been aware the medication was available in the medication back up system at the facility. The DON stated she could not explain the circumstances surrounding the discontinuation of the Oxybutynin and expected medication to be given to residents as ordered. The DON stated prior to 10/17/17 she was not aware the Oxybutynin was not available to be given or that it had not been given to Resident #1. On 10/17/17 at 6:44 PM the physician of Resident #1 stated he expected medication to be given as ordered but noted the 5 missing doses of Oxybutynin would not have caused any harm to Resident #1. On 10/17/17 at 7:00 PM the Administrator stated she expected medication to be available to be given as ordered.	F 425	achieved and the committee recommends quarterly oversight by the Division Director of Clinical Services to maintain compliance when completing facility reviews.	