STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345411	A. BUILDING _____ B. WING _____	R-C 04/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE	516 WALL STREET WAYNESVILLE, NC 28786

(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 431} SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	{F 431}	All PRN (as needed medications) records and Narcotic count down sheets for residents, will be audited by the Director of Nursing, Unit Coordinator's, Medical Records and Staff Development Coordinator for accuracy, and were corrected by Licensed Nurse and/or Certified Medication Aide immediately. Licensed Nurse 1and 2 along with Certified Medication Aide 1 and 2 were in-serviced 1:1 and disciplinary action was given. New PRN (as needed medication sheets) were put into place to eliminate duplicate documentation and improve accuracy. The Director of Nursing, Staff Development Coordinator, Unit Coordinators and Medical Records are auditing records every other day on a on going/permanent basis for any discrepancies, 100% of all Medication Administration records, PRN (as needed medication records and Narcotic count down sheets) are audited.	5/16/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN — TITLE: Director of Nursing — (X6) DATE: 5-16-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DHSR NH Asheville Black Mountain MRO Received MAY 10 2013 by: PRM

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{F 431}	Continued From page 1 Based on medical record reviews and staff interviews the facility failed to have matching documentation on the front and back of the Medication Administration Record (MAR) and the declining inventory record for the administration of narcotic as needed (PRN) pain medication for 2 of 3 sampled residents. (Residents #3 and 4). The findings included: 1. Resident (#4) was admitted to the facility 04/20/12 with diagnoses which included open wounds and pressure ulcer. The most recent Minimum Data Set (MDS) dated 03/25/13, assessed the resident as being cognitively intact for daily decision making and as having no short term or long term memory problems. The MDS indicated Resident #4 received scheduled pain medication and PRN medication for pain. Resident #4 was assessed as having almost constant pain which was at a severity level of 10 on a scale of 0 to 10, with 10 indicating the most severe pain and 0 indicating no pain. A review of the April 2013 recapitulation of physician orders revealed Resident #4 had orders for oxycontin 80 milligrams (mg) extended release two tablets orally every 8 hours on a routinely scheduled basis and oxycodone 30 mg two tablets orally every 6 hours as needed (PRN). Both medications are used to treat pain. Review of Resident #4's April 2013 Medication Administration Record (MAR) and declining inventory record for oxycodone 30 mg PRN for pain revealed discrepancies in the documentation of administration of the medication. The discrepancies were as follows:	{F 431}	The facility realizes the potential for this alleged deficient practice could affect other residents. Staff Development, Unit coordinators, and Medical Records will report to Director of Nursing with findings for further intervention or disciplinary action if needed. Director of Nursing or Administrator will prepare and submit a summary for QAPI meeting monthly, for any further intervention needed.	5/16/2013

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{F 431}	Continued From page 2 A. Medication Aide #2 documented on 04/08/13 at 01:00 PM on the declining inventory record that he administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered. B. Nurse #4 documented on 04/12/13 at 02:30 PM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered. C. Nurse #3 documented on 04/14/13 at 02:30 AM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered. D. Nurse #3 documented on 04/14/13 at 05:00 PM on the declining inventory record that she administered 2 oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered. Nurse # 4 was not available for interview during the survey. An interview with Medication Aide #2 on 04/16/13 at 04:01 PM revealed he was responsible for administering PRN medications on 04/08/13 for Resident #4. He stated that the expectation was to document administration of all PRN medications by placing his initials on the front of the MAR; then to document the date, time, and name, strength, and dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Medication Aide # 2 stated that controlled narcotics should	{F 431}		

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{F 431}	Continued From page 3 also be documented on the declining inventory record and that the documentation should match in all three places. Medication Aide # 2 confirmed that he gave the medication as he had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/08/13 at 01:00 PM. Medication Aide # 2 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications. An interview with Nurse #3 on 04/16/13 04:11 PM revealed she was responsible for administering PRN medications on 04/14/13 for Resident #4. She stated that the expectation was to document administration of all PRN medications by placing her initials on the front of the MAR; then to document the date, time, and name, strength, dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Nurse #3 stated that controlled narcotics should also be documented on the declining inventory record and that the documentation should match in all three places. Nurse #3 confirmed that she gave the medications as she had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/14/13 at 02:30 AM and 05:00 PM. Nurse #3 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications. An interview with the Director of Nursing (DON) on 04/16/13 at 04:35 PM revealed she expected staff to document administration of all PRN medications by placing their initials on the front of the MAR; then to document the date, time, name,	{F 431}		