STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/03/2016

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BRIAN CENTER H & REHAB WEAVERV	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 3 of 24 sampled residents utilizing the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for (Resident #15), hospice care for (Resident #90)	F 278	F278 SS=D Alleged deficient practice in Assessment Accuracy/Coordination/Certified Criteria #1 Corrective action has been accomplished for the alleged deficient practice with regard to resident #15, resident #90, and resident #182. The assessments dated 11/12/15 was modified to show Level II PASRR 03/01/16 and accepted by CMS on 03/01/16. The significant change assessment dated 12/23/16 was modified on 03/01/16 and accepted by CMS on 03/01/16 to show that the Hospice services were initiated. The care plan for resident #182 was modified on 03/01/16 to reflect choice of wearing glasses used for reading only. Next assessment due 04/4/16 will be completed according to RAI guidelines and reviewed by RN MDS Coordinator. Criteria #2 Facility residents who have the potential to be affected by the same alleged deficient practice for accurate coding of Level II PASRRs will be identified through audit of currently admitted residents by the social worker. A list of Level II PASRRs will be provided by social worker and maintained in a separate binder in the MDS office to ensure MDS is aware of all Level II PASRR for accurate coding. Only 1 MDS out of 3 identified with Level II PASRRs were identified through MDS audit completed	

DHSR NH L&C Black Mountain WRO Received MAR 21 2016 by: SKH

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

3-21-16

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.

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F 278	Continued From page 1 and vision for (Resident #182). Findings included: 1. Resident #15 was admitted to the facility on 03/08/2011 with diagnoses including schizophrenia, non-Alzheimer's dementia, and anxiety disorder. A review of Resident #15's annual Minimum Data Set (MDS) dated 11/12/15 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review were used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility's list of Level II PASRR residents revealed that Resident #15 was included among the residents named on the list. The MDS Coordinator #1 was interviewed on 03/01/16 at 3:12 PM, regarding the accuracy of Resident #15's annual MDS. When it was revealed the MDS did not reflect the Level II PASRR determination for this resident, the MDS Coordinator #1 stated the MDS should have been coded to reflect Resident #15 was Level II PASRR and was missed for coding. On 03/01/16 at 4:07 PM, the Director of Nursing (DON) was interviewed. The DON stated it was her expectation that the Level II PASRR determination would have been coded accurately on Resident #15's MDS. The DON stated it was her expectation that the MDS Coordinator would submit a modified annual MDS to reflect Level II PASRR for Resident #15. On 03/01/16 at 4:18 PM, the Administrator was	F 278	residents with level II PASRR as described in the RAI Manual Section A1500 and NC DHHS PASRR Provider Manual regarding preadmission screens and Level II PASARR requirements. The Social Worker will maintain a copy of all PASRR screens and a separate list of residents and admitting residents with PASRR Level II screens, copy of list and updated list of PASRR Level II residents to be placed in a binder in the MDS office. The Resident Care Management Director will audit 10 of either admission/annual/significant change assessments per month by no later than the last day of the month to ensure accurate coding of PASRR Level for a period of 3 months. The Resident Care Management Director educated MDS Coordinators on Section O of the RAI Manual on 3/1/16 for accurate coding of the MDS assessment. To ensure this practice does not occur again, the RCMD will pull weekly census data of residents receiving Hospice services and review completed MDS assessments prior to transmission to ensure no further residents will be affected for a period of 3 months. The Resident Care Management Director educated the MDS coordinators 3/1/16 on Section B regarding assessments for vision per RAI guidelines on use of eyeglasses and adjusting lighting to identify problems with vision and to ensure adequate	

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F 278	Continued From page 2 interviewed. The Administrator stated it was her expectation that the Level II PASRR determination would have been coded accurately on Resident #15's MDS. 2. Resident #90 was admitted to the facility on 12/23/14 with diagnoses including Alzheimer's disease, dementia, depression, and anxiety disorder. The physician's order dated 12/15/15 revealed Resident #90 was accepted for hospice care. A review of the medical record revealed Resident #90 began receiving hospice care on 12/16/15. A review of the facility's list of hospice residents revealed that Resident #90 was included among the residents on the list. A review of Resident #90's significant change Minimum Data Set (MDS) dated 12/23/15 did not indicate Resident #90 had received hospice care. The MDS Coordinator #1 was interviewed on 03/01/16 at 9:05 AM, regarding the accuracy of Resident #90's significant change MDS. The MDS Coordinator #1 stated the significant change MDS should have been coded to reflect Resident #90 received hospice care. On 03/01/16 at 9:18 AM an interview was conducted with the MDS Coordinator #2 who stated she coded the significant change MDS for Resident #90 and forgot to code Resident #90 received hospice care. On 03/01/16 at 10:45 AM, the Director of Nursing (DON) was interviewed. The DON stated it was	F 278	documentation as verified by RN MDS Coordinator. To ensure this practice does not occur again, the RCMD will audit all assessments completed by LPN MDS Coordinator for verified documentation by RN of assessment in progress notes for 30 days, initiated with all assessments completed 3/1 through 3/31, and for an additional 2 months, RCMD will audit 10 assessments completed by LPN MDS Coordinator to ensure ongoing practice. All audits will be completed Criteria #4 The Resident Care Management Director will review data obtained during assessment audits, analyze the data and report patterns/ trends to the QAPI committee every month x 3 months. The QAPI committee will evaluate the effectiveness of the above plan, and will add interventions based on identified trends/ outcomes to ensure continued compliance.	March 31st 2016

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F 278	Continued From page 3 her expectation that the significant change MDS would have been coded accurately to reflect Resident #90 received hospice care. On 03/01/16 at 10:50 AM, the District Clinical Director (DCD) was interviewed. The DCD stated she completed quarterly MDS audits and missed that Resident #90's significant change MDS was not coded for hospice care. On 03/01/16 at 11:16 AM, the Administrator was interviewed. The Administrator stated it was her expectation that significant change MDS would have been coded accurately to reflect Resident #90 received hospice care. 3. Resident #182 was admitted to the facility on 10/07/15 with diagnoses including anemia, dementia, hypertension, and diabetes mellitus. A review of Resident #182's care plan dated 10/13/15 revealed a problem of sensory deficit related to wears glasses for reading. Interventions included: Staff were to assure Resident #182 had the appropriate visual aide available as necessary. Staff were to assure glasses were within easy reach for Resident #182. A review of Resident #182's quarterly Minimum Data Set (MDS) dated 01/11/16 revealed impaired vision with no corrective lenses. The MDS Coordinator #3 was interviewed on 03/01/16 at 9:34 AM, regarding the accuracy of Resident #182's quarterly MDS. The MDS Coordinator #3 stated that Resident #182 wore glasses for reading and she did not attempt to have Resident #182 wear his glasses during the vision assessment. The MDS Coordinator #3 stated Resident #182 should have been wearing his glasses during the vision exam for accuracy of coding the MDS.	F 278		

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F 278	Continued From page 4 On 03/01/16 at 9:59 AM an interview was conducted with the MDS Coordinator #2 who stated she signed the quarterly MDS for Resident #182 and did not realize that he had not worn glasses during the vision exam. The MDS Coordinator #2 stated the Assessment Reference Date (ARD) and the quarterly MDS date were 01/11/16 and she would not have had time to perform another vision exam for Resident #182 with his glasses on. On 03/01/16 at 10:54 AM, the Director of Nursing (DON) was interviewed. The DON stated it was her expectation that the quarterly MDS vision assessment would have been conducted with Resident #182 wearing his glasses. The DON stated it was her expectation that the vision assessment conducted by the MDS Coordinator #3 would have been accurately completed prior to the MDS Coordinator #2 signing the quarterly MDS for Resident #182. On 03/01/16 at 11:22 AM, the Administrator was interviewed. The Administrator stated it was her expectation that the quarterly MDS vision assessment would have been conducted with Resident #182 wearing his glasses. The DON stated it was her expectation that the vision assessment conducted by the MDS Coordinator #3 would have been accurately completed prior to the MDS Coordinator #2 signing the quarterly MDS for Resident #182.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain lab work for 1 of 6 residents with medications reviewed. (Resident #199) The findings included: Resident #199 was admitted to the facility 02/02/16 after hospitalization with diagnoses which included enterococcus, sepsis, chronic gout, chronic kidney disease, hypokalemia, low back pain, hypertension, atherosclerotic heart disease, atrial fibrillation, ischemic cardiomyopathy and hyperlipidemia. a. Admission physician orders for Resident #199 included Coumadin (a blood thinner) .5 milligrams (mg) every day and next Prothrombin time (PT) International Normalized Ratio (INR) due 02/03/16 with a target INR of 2-3. The PT/INR is a test used to monitor Coumadin dosage. A PT/INR result was not located from 02/03/16 in the medical record of Resident #199. On 03/02/16 at 10:09 AM the interim Director of Nursing (DON) explained the facility system for monitoring residents on Coumadin. The interim DON stated the Coumadin was entered on the Medication Administration Record (MAR) and scheduled to be given through the day before the PT/INR was due. The interim DON stated the PT/INR results were reported to the physician to determine any dosing changes needed for residents on Coumadin. The interim DON stated the Coumadin would not be restarted until the PT/INR results were back and new orders were obtained from the physician. The interim DON	F 281	F281 1.Corrective action was taken for the residents affected by the alleged deficient practice by drawing the missing lab work on 2/26/16. Results were received and faxed to the attending physician. 2.A facility wide lab audit was conducted by DON on 2/26/16 on all ordered labs to determine if other residents were affected by the alleged deficient practice. There were no additional missing labs. 3.To prevent this alleged deficient practice from occurring again. DON in-serviced all nurses on 03/4/16 to enter each lab order received from a physician into PCC and make out a lab slip. The nurse puts the lab slip in the lab	

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F 281	Continued From page 6 stated when the first PT/INR results were obtained it triggered the nurse to complete an Anticoagulant Therapy Flow Sheet for the individual resident. The interim DON stated the Anticoagulant Therapy Flow Sheet was used to track Coumadin dosing and PT/INR results for each resident on Coumadin. The interim DON stated because the initial PT/INR had not been done for Resident #199 the Anticoagulant Therapy Flow Sheet was not initiated. The interim DON stated, if the Anticoagulant Therapy Flow Sheet had been initiated for Resident #199 it should have triggered nursing staff of the missing PT/INR. Review of the February MAR for Resident #199 noted the Coumadin was given 02/02/16 and not administered again until 02/29/16. Review of the Anticoagulant Therapy Flow Sheet for Resident #199 noted the first recorded PT/INR results were from 02/29/16 with test results documented as 12.9/1.0. On 03/02/16 at 11:35 AM the current DON stated the PT/INR ordered on 02/03/16 had not been done as ordered. The current DON stated facility staff became aware Resident #199 had not been on Coumadin the end of February and lab work was obtained and the Coumadin restarted. The current DON could not explain why the 02/03/16 PT/INR had not been done for Resident #199. The current DON stated the facility was in the process of making changes to the lab work system to prevent issues with lab work in the future. On 03/02/16 at 1:45 PM the facility Medical Director stated lab work should be completed for residents as ordered. The Medical Director	F 281	book for that hall. The phlebotomist from the hospital comes four days a week and draws the ordered labs. The nurse on the hall draws labs the remaining three days or when the patient has a central line in place. The yellow copy of the lab slip is left with the nurse at the nurses' station which is picked up by the Unit Manager for that hall. Unit Coordinator created a lab book on March 7, 2016 for each nurses station. Lab orders are printed daily from PCC by the DON and given to the Unit Manager of the hall who verifies that the labs for that day were drawn by picking up the yellow copy of the lab slip left by the phlebotomist or nurse, verifies results have been received, and verifies that results are faxed to the	

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F 281	Continued From page 7 stated though the 02/29/16 PT/INR results were subtherapeutic for Resident #199 he did not feel it had caused any harm because of the low dose of Coumadin taken by the resident. On 03/02/16 at 2:52 PM the interim DON stated she had been in contact with the lab and they noted in their records the 02/03/16 lab for a PT/INR had been canceled by someone at the lab. The interim DON stated the lab could offer no explanation for the cancellation. On 03/03/16 at 11:35 AM the Physician Assistant for Resident #199 stated she expected lab work to be done as ordered. The Physician Assistant stated the 02/03/16 PT/INR should have been done as ordered for Resident #199 so the dosing of Coumadin could be reviewed and orders obtained for continuation of Coumadin. b. Admission physician orders for Resident #199 included Ampicillin (an antibiotic) 2 grams intravenously every 6 hours for 42 days and obtain weekly Complete Blood Count with differential (CBC w/diff), Chemistry 7 and Liver Function Test (LFT). On 03/02/16 at 10:09 AM the interim Director of Nursing (DON) stated she transcribed admission orders for Resident #199 on 02/02/16. The interim DON stated when lab orders were put into the facility electronic system they were scheduled for current and future needs. The interim DON stated since the Ampicillin was ordered for 42 days the CBC w/diff, Chemistry 7 and LFT would have been entered in the electronic system to be done 02/08/16, 02/15/16 and 02/22/16. On 03/02/16 at 11:35 AM the interim DON and	F 281	attending physician. These daily audits conducted by unit coordinator/ADON/unit supervisor will continue indefinitely. In addition to the lab book at each nurses station we have another book containing the PTI&R flow sheets. Each day the Unit Coordinator reviews the flow sheets and flags the PTI&R that are due the next day and then verifies each day that they were completed. The DON prints out a daily list of orders from PCC. Each order on the list is compared to the phone orders on the chart and the yellow copy of each written doctor order to verify accuracy by the Unit Manager.	

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F 281	Continued From page 8 current DON stated they were unaware the weekly CBC w/diff, Chemistry 7 and LFT for Resident #199 due 02/08/16, 02/15/16 and 02/22/16 had not been completed and could offer no explanation for the omission. The current DON stated the facility was aware there were issues with lab work being completed and the facility was in the process of making changes to the lab work system to prevent issues with lab work in the future. Review of lab work in the medical record of Resident #199 noted the results of the CBC w diff, Chemistry 7 and LFT from 02/08/16, 02/15/16 and 02/22/16 were not included in the medical record. On 02/23/16 a physician's progress note in the medical record of Resident #199 noted concern with increased fluid/swelling and a Metabolic Package was ordered. A Comprehensive Metabolic Panel was done 02/24/16 with a potassium level of 3.0 (with the normal range of 3.5-5.1). As a result of the labwork, on 02/25/16 the physician ordered 20 milliequivalents of Potassium Chloride three times a day for Resident #199. Potassium levels would have been included in lab work had labs been done as ordered on 02/08/16, 02/15/16 and 02/22/16. On 03/02/16 at 1:45 PM the facility Medical Director stated lab work should be completed for residents as ordered. On 03/03/16 at 11:35 AM the Physician Assistant for Resident #199 stated she expected all lab work to be done as ordered for residents.	F 281	4.Measures put in place to assure that the alleged deficient practice does not reoccur include a weekly audit of 100% of the Coumadin flow sheets and an audit of 25% of the all labs each week for 90 days or as recommended by the QAPI Committee. A **monthly summary** of the audit results will be presented to QAPI and the committee will recommend changes to the POC if needed.	March 31st 2016
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

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F 333	Continued From page 9 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to obtain lab work which affected anti-coagulant medication being administered to 1 of 6 residents with medications reviewed. (Resident #199) The findings included: Resident #199 was admitted to the facility 02/02/16 after hospitalization with diagnoses which included hypertension, atherosclerotic heart disease, atrial fibrillation, ischemic cardiomyopathy and hyperlipidemia. Admission physician orders for Resident #199 included Coumadin (a blood thinner) .5 milligrams (mg) every day and next Prothrombin time (PT) International Normalized Ratio (INR) due 02/03/16 with a target INR of 2-3. The PT/INR is a test used to monitor Coumadin dosage. A physician's progress note in the medical record of Resident #199 dated 02/04/16 noted Resident #199 had a diagnosis which included atrial fibrillation with plans to continue Coumadin. On 03/02/16 at 10:09 AM the interim Director of Nursing (DON) explained the facility system for monitoring residents on Coumadin. The interim DON stated the Coumadin was entered on the Medication Administration Record (MAR) and scheduled to be given through the day before the PT/INR was due. The interim DON stated the	F 333	F333 1.Corrective action was taken by the unit coordinator on 2/29/16 for the resident #199 affected by the alleged deficient practice by completing a medication review and restarting the medication based on the lab value received on 2/29/16 per MD order. 2.Facility wide audit of all residents on Coumadin was completed by DON on 2/29/16 to determine potential residents that could be affected by the alleged deficient practice. No additional errors were identified in this audit.	

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BRIAN CENTER H & REHAB WEAVERV	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

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F 333	Continued From page 10 PT/INR results were reported to the physician to determine any dosing changes needed for residents on Coumadin. The interim DON stated the Coumadin would not be restarted until the PT/INR results were back and new orders were obtained from the physician. The interim DON stated when the first PT/INR results were obtained it triggered the nurse to complete an Anticoagulant Therapy Flow Sheet for the individual resident. The interim DON stated the Anticoagulant Therapy Flow Sheet was used to track Coumadin dosing and PT/INR results for each resident on Coumadin. The interim DON stated because the initial PT/INR had not been done for Resident #199 the Anticoagulant Therapy Flow Sheet was not initiated. The interim DON stated, if the Anticoagulant Therapy Flow Sheet had been initiated for Resident #199 it should have triggered nursing staff of the missing PT/INR and Coumadin order. Review of the February MAR for Resident #199 noted the Coumadin was given 02/02/16 and not administered again until 02/29/16. Review of the Anticoagulant Therapy Flow Sheet for Resident #199 noted the first recorded PT/INR results were from 02/29/16 with test results documented at 12.9/1.0. A PT/INR result was not located from 02/03/16 in the medical record of Resident #199. On 03/02/16 at 11:35 AM the current DON stated the PT/INR ordered on 02/03/16 had not been done as ordered. The current DON stated facility staff became aware Resident #199 had not been on Coumadin the end of February and lab work was obtained and the Coumadin restarted. The current DON could not explain why the 02/03/16 PT/INR had not been done for Resident #199 and noted because it had not been done facility staff	F 333	3.To prevent any further alleged deficient practice the facility has implemented daily order checks completed byunit coordinator/ADON/week end supervisor to ensure accuracy of order entered. Anti-coagulation Flow Sheet is initiated by hall nurse when the medication is ordered by the physician. Daily audits of Anti-coagulation Flow sheets are done by unit coordinator/ADON/week end supervisor to insure the appropriate monitoring and follow up in correlation of the order review. The Director of Nursing assures the daily review is completed by nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 333	Continued From page 11 was unaware Resident #199 had not received Coumadin until 02/29/16. The current DON stated the facility was in the process of making changes to the lab work system to prevent issues with lab work in the future. On 03/02/16 at 1:45 PM the facility Medical Director stated lab work should be completed for residents as ordered. The Medical Director stated though the 02/29/16 PT/INR results were subtherapeutic for Resident #199 he did not feel it had caused any harm because of the low dose of Coumadin taken by the resident. On 03/02/16 at 2:52 PM the interim DON stated she had been in contact with the lab and they noted in their records the 02/03/16 lab for a PT/INR had been canceled by someone at the lab. The interim DON stated the lab could offer no explanation for the cancellation. On 03/03/16 at 11:35 AM the Physician Assistant for Resident #199 stated she expected lab work to be done as ordered. The Physician Assistant stated the 02/03/16 PT/INR should have been done as ordered for Resident #199 so the dosing of Coumadin could be reviewed and orders obtained for continuation of Coumadin.	F 333	management. All staff were educated by ADON on 2/29/16 on the importance of accuracy of the medication order and importance of follow up to medication monitoring. The daily medication/Anti-Coagulation Flowsheet audit will continue daily for 4 weeks, then will be done weekly indefinite. 4.To assure continued compliance with these processes the DON will evaluate audit results and present these results to QAPI on monthly basis. The QAPI committee will recommend any needed changes.	March 31st 2016