STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & REHAB	1306 SOUTH KING STREET WINDSOR, NC 27983

(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 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey of 6/16/16. Event ID SDZ311.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to identify a significant change in status for 1 of 1 (Resident #31) residents reviewed for hospice. Findings included: Resident #31 was admitted to the facility on 1/19/10. His current diagnoses included anemia, hypertension, Alzheimer's dementia and hemiplegia. A medical record review revealed an Informed Consent/Election of Benefits for Hospice services signed by Resident #31's physician and dated 2/26/16. Documents labeled Hospice IDG	F 274	1. The Significant Change (Sig. Change) assessment was completed for resident #31. 2. All other residents currently receiving Hospice Services will be audited by 6-22-16 to ensure a Sig. Change was done and transmitted to the state. 3. The District Director of Care Management (DDCM) will inservice the MDS Nurse, Director of Nursing and the Administrator on the process when determining if a resident needs a Sig. Change Assessment completed by 6-24-	6/29/16

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

Electronically Signed | 06/24/2016

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 274	Continued From page 1 (Interdisciplinary Group) notes for 3/10/16, 3/23/16 and 4/6/16 which included assessments and care plans completed by the Hospice nurse were included in Resident #31's chart. Resident #31's most recent quarterly Minimum Data Set (MDS) of 4/13/16 indicated he was severely cognitively impaired. The Staff Assessment of Resident Mood indicated he had little interest or pleasure in doing things, feeling tired or having little energy and poor appetite. The MDS revealed that he required extensive to total assistance with all activities of daily living. The MDS did not indicate Resident #31 was receiving any special treatments, procedures or programs. An interview was conducted 6/15/16 at 9:19 AM with the MDS nurse. He stated he had started in that position on 4/25/16. He stated he knew that a Significant Change in Status should be completed when a resident was started on hospice care but it was missed by the agency nurse who had been doing MDS in February. An interview was conducted on 6/15/16 at 9:29 AM with the Director of Nursing. She stated she would expect the MDS nurse to complete a Significant Change in Status for a resident electing hospice. She stated hospice residents were discussed every morning in the staff meeting. An interview was conducted 6/15/16 at 10:10 AM with the Administrator. She stated it was her expectation that the MDS nurse would capture the order for hospice and complete a Significant Change in Status.	F 274	16. The nursing staff will be inservice by 6 -27-16 on ensuring an order is written in the chart if Hospice Services is started and pink copies of all orders written will be brought to morning meeting to be reviewed by the IDT team Monday through Friday. 4. The Administrator will audit assessments for four weeks then a sample for four weeks to ensure the type of assessments done are correct weather a quarterly, annual or a Sig. Change. The results of all audits will be taken to the Monthly QAPI meetings for two months.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		6/29/16

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F 278	Continued From page 2 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 the Minimum Data Set (MDS) assessment for 3 of 13 residents reviewed (Resident #23, #43 and #75). Findings included: 1. Resident #23 had been admitted to the facility on 1/28/2016. Admitting diagnoses included: chronic obstructive pulmonary disease (COPD), muscle weakness, pain in limb, lack of	F 278	1. The assessments for #23, 43 and #75 were modified and transmitted. 2. An audit of current residents will be completed by the Administrator by 6-22-16 to ensure falls and medical diagnosis have been coded on any assessments with the ARD date within the last 30 days. Any assessments found to be incorrect will be modified by 6-24-16.	

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F 278	Continued From page 3 coordination, gout, atrial fibrillation, difficulty walking, dysphagia, and acute on chronic respiratory failure. Resident #23's most recent quarterly MDS assessment dated 4/25/2016 indicated she had received insulin, antipsychotic and diuretic medications. The assessment also indicated she used an indwelling urinary catheter and required staff assistance with activities of daily living (ADL). No diagnoses were included with this assessment. An interview with the MDS nurse was conducted on 6/15/2016 at 11:40 AM. The MDS nurse stated the diagnoses had not been captured on Resident #23's MDS assessment and the MDS assessment should have been checked for accuracy. An interview with the Administrator (AD) was conducted on 6/16/2016 at 9:30 AM. The AD stated it was her expectation for the MDS to be accurate and to reflect the resident's status and to include medical diagnoses 2. Resident #43 had been admitted to the facility on 9/29/2014. Admitting diagnoses included: seizures/epilepsy, hypertension, vertigo, dizziness, generalized pain, coronary artery disease, hyperlipidemia, dementia, anxiety, and insomnia and sleeplessness disturbances. Resident #43's most recent quarterly MDS assessment dated 5/13/2016 indicated she had received antianxiety, antidepressant and diuretic medications. The assessment also indicated she required staff assistance with ADLs. No diagnoses were included with this assessment. An interview with the MDS nurse was conducted on 6/15/2016 at 11:40 AM. The MDS nurse stated the diagnoses had not been captured on Resident #43's MDS assessment and the MDS assessment should have been checked for	F 278	3. The District Director of Care Management (DDCM) will inservice the MDS Nurse, Director of Nursing and the Administrator on coding section I as it relates to coding medical diagnosis and section J as it relates to coding falls by 6-24-16. 4. The Administrator will audit assessments for four weeks then a sample for four weeks to ensure coding is correct for medical diagnosis and falls. The results of all audits will be taken to the Monthly QAPI meetings for two months.	

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F 278	Continued From page 4 accuracy. An interview with the Administrator (AD) was conducted on 6/16/2016 at 9:30 AM. The AD stated it was her expectation for the MDS assessment to be accurate and to reflect the resident's status and to include medical diagnoses. #3. Resident # 75 was admitted to the facility on 2/4/2015, with diagnoses to included stroke with hemiplegia. Two "Interdisciplinary Post Fall Reviews" were inspected for falls by Resident #75, which occurred on 3/28/2016, and 4/10/2016. Resident #75's quarterly Minimum Data Set (MDS) assessment dated 4/11/2013, revealed her cognition to be intact. She required extensive assistance for activities of daily living (ADL) and had no falls. On 6/15/2016 at 11:40 AM, an interview was conducted with the MDS nurse. The MDS nurse stated he gathered information to complete assessments by reviewing a resident's medical record, as well as interviews with staff and residents. The MDS nurse stated Resident #75 had falls prior to the MDS assessment of 4/11/2016, and those falls should have been reflected on the assessment. An interview was conducted on 6/15/2016 at 11:56 AM with the Administrator. The Administrator stated she expected the MDS assessment to reflect the resident's status accurately.	F 278		
F 287 SS=D	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility	F 287		6/29/16

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F 287	Continued From page 5	F 287		

completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

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F 287	Continued From page 6 (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit a Minimum Data Set (MDS) assessment within 3 months for 1 of 13 residents reviewed (Resident #35). Findings included: Resident #35 had been admitted to the facility on 7/19/2010. Resident #35's most recent quarterly MDS assessment was dated 2/16/2016. A review of the Centers for Medicare and Medicaid Services (CMS) MDS database was made on 6/14/2016 and revealed no further MDS assessments had been received by CMS. An interview with the MDS nurse was conducted on 6/15/2016 at 12:06 PM. The MDS nurse stated an annual assessment had been completed for Resident #35 with an Assessment Reference Date (ARD) of 5/16/2016. The nurse stated his computer indicated the MDS assessment had been transmitted to CMS. The MDS nurse had been unable to locate the transmission verification report which showed Resident #35's MDS assessment had been received and accepted by CMS. An interview with the MDS nurse was conducted	F 287	1. The assessments for resident # 35 has been transmitted with a validation report stating “accepted” from CMS. 2. An audit will be completed by the Administrator by 6-22-16 of current assessments to ensure the current assessment in Care Central have been accepted by CMS. Any assessments found not to be accepted will be re-open and transmitted by 6-24-16. 3. The District Director of Care Management (DDCM) will inservice the MDS Nurse, Director of Nursing and the Administrator on ensuring when transmitting to CMS reading assessments are accepted by 6-24-16. 4. The Administrator will audit assessments for four weeks then a sample for four weeks to ensure validation reports are reflecting assessments transmitted have been accepted with no errors. The results of all audits will be taken to the Monthly QAPI meetings for two months.	

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F 287	Continued From page 7 on 6/16/2016 at 9:00 AM. The nurse stated Resident #35's annual MDS assessment dated 5/16/2016 had been transmitted and accepted by CMS on 6/15/2016. The nurse stated he thought the assessment had been previously transmitted. An interview with the Administrator (AD) was conducted on 6/16/2016 at 9:30 AM. The AD stated it was her expectation for the MDS to be transmitted according to CMS guidelines.	F 287		
F 431 SS=D	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	F 431		6/29/16

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F 431	Continued From page 8 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: Based on observation, staff interviews and review of manufacturer's recommendations, the facility failed to date a perishable multi-dose tuberculin vial for 1 of 1 refrigerators. Findings included: Observation of the medication storage room on 6/15/16 at 4:40 PM revealed an open vial of Tubersol 5U/0.1ml (a solution used to test for Tuberculosis) in the refrigerator. There was no date of opening recorded on the vial label. The manufacturer's recommendation included: "A vial of Tubersol {Tuberculin Purified Protein Derivative [Mantoux]} which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Do not use after expiration date." On 6/15/16 at 4:41 PM, an interview was conducted with Nurse #1. She stated it is the responsibility of the nurse who first opens the vial to write an opened date on the label. On 6/15/16 at 4:42 PM, an interview was conducted with the Director of Nursing. She stated it was her expectation for all nurses to date Tuberculin vials when they were opened. On 6/15/16 at 4:43 PM, an interview was conducted with the Administrator. She stated it was her expectation that all medication should be dated when opened.	F 431	1. The perishable multi-dose tuberculin vial was discarded on 6-15-16 2. All other storage areas were checked for any multi-dose medication to ensure they were dated. 3. The nurses will be inserviced by Assistant Director of Nursing to be completed by 6-27-16 on the importance of dating any multi- dose medication that have been opened. Any staff member not inserviced by that date will be prior to working another shift. 4. The Director of Nursing or Asst. Director of Nursing will audit three times a week for 4 weeks and then weekly for four weeks to ensure all storage areas are free from open undated multi-dose medications. If any are found the Director of Nursing or Asst. Director of Nursing will inservice that staff member one on one on the proper procedure of dating open medications. The results of all audits will be taken to the Monthly QAPI meetings for two months.	

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