STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHABILITATIO	647 S RAILROAD STREET BOX 966 WALLACE, NC 28466

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure dignity during dining by failing to ensure staff were seated while feeding 3 of 3 sampled residents (Resident #1, #8 & #9). The findings included: 1. Resident #1 was admitted to the facility on 03/31/14 with a diagnosis of Dementia. Review of Resident #1's current care plan, which was revised on 09/05/16, indicated staff were to assist the resident with meals. The Quarterly Minimum Data Set (MDS) dated on 09/07/16 indicated Resident #1 had severely impaired cognitive skills for daily decision making. The resident was coded as needing extensive assistance with one person physical assistance with eating. Observation was made on 09/29/16 at 6:06 PM to 6:28 PM of Resident #1, who was seated in her wheel chair in her room, and Nursing Assistant #2 (NA) was standing while feeding the resident dinner. During an interview on 09/29/16 at 6:35 PM, NA	F 241	The facility continue to strive to promote care for our residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. Nursing assistant #2, #3 and #4 were provided direct re- education regarding dignity and respect of a resident. The re-education included ensuring that a staff member was seated while feeding a resident. The education was provided on 9/29/16 by ADON. The Director of Nursing and Assistant Director of Nursing completed an observation audit of facility residents requiring assistances with feeding on 10/3/16 recording observations on checklist to ensure that staff was seated during feeding of the resident. The facility Staff Development Coordinator will provide re- education to direct care staff regarding dignity and respect of resident, to include ensuring that a staff member is seated while feeding a resident on 9/29/16 □ 9/30/16 and complete by DON. Newly hired direct care staff will receive the education during orientation. Facility staff that does not	10/27/16

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

Electronically Signed | 10/23/2016

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 241	Continued From page 1 #2 indicated that she normally sits down when she assisted residents with their meals but the present situation in the room with both residents seated side by side in their wheel chairs made it was easier for her to stand while she fed Resident #1. During an interview on 09/29/16 at 7:14 PM, the Director of Nursing indicated that it is her expectation that the staff is seated while feeding residents. 2. Resident #8 was admitted to the facility on 05/20/16 with a diagnoses of Dementia, Glaucoma/Cataracts and Blindness. Review of Resident #8's current care plan, which was revised on 08/01/16, indicated staff were to assist the resident with meals. The Quarterly MDS dated on 09/02/16 indicated Resident #8 had moderately cognitive skills for daily decision making. The resident was coded as needing extensive assistance with one person physical assistance with eating. Observation was made on 09/29/16 at 6:08 PM to 6:45 PM of Resident #8 in his room lying in bed and Nursing Assistant (NA) #3 was standing while feeding the resident dinner. During an interview on 09/29/16 at 6:46 PM, NA #3 indicated that she normally stands and sometimes she will sit down to feed residents. During an interview on 09/29/16 at 7:14 PM, the Director of Nursing indicated that it is her expectation that the staff is seated while feeding residents.	F 241	receive the re- education on 9/29/16 □ 9/30/16 will receive prior to working next scheduled shift. The Facility Director of Nursing or designee will complete two observation of residents requiring assistances with feeding weekly times four an d monthly times two, to ensure that residents are seated during feeding of a resident. All meals will be monitored. The Facility Director of Nursing will report finding of the observation to the QAPI committee monthly times three. The committee will review finding and determine if further action is needed.	

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F 241	Continued From page 2 3. Resident #9 was admitted to the facility on 12/04/12 with a diagnoses of Dementia and Glaucoma/Cataracts. The Quarterly MDS dated on 08/09/16 indicated Resident #9 had severely impaired skills for daily decision making. The resident was coded as needing extensive assistance with eating. Review of Resident #9's current care plan, which was revised on 08/22/16, indicated staff were to assist the resident with meals. Observation was made on 09/29/16 at 6:18 PM to 6:25 PM of Resident #9 in her room lying in bed and Nursing Assistant (NA) #4 was standing while feeding the resident dinner. During an interview on 09/29/16 at 6:48 PM, NA #4 indicated that she knew she should down when feeding a resident but stuff was in the chair in the resident ' s room and she decided to stand up while she fed Resident #9. During an interview on 09/29/16 at 7:14 PM, the Director of Nursing indicated that it is her expectation that the staff is seated while feeding residents.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		10/27/16

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F 279	Continued From page 3 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 9 residents (Resident #5) with care plans reviewed. The findings included: Resident #5 was admitted to the facility on 7/18/16 from an acute care hospital. His cumulative diagnoses included Alzheimer's disease and adult failure to thrive. A review of Resident #5's admission MDS (Minimum Data Set) assessment dated 7/25/16 revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of his Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with transfers and personal hygiene. The resident had highly impaired vision, was always incontinent of	F 279	The facility will continue to strive to use the results of the assessment to develop, review and revise the resident□s comprehensive plan of care. Resident #5 assessment dated 7/25/16 reviewed and comprehensive care plan was developed on 10/3/16 by MDS coordinator. The District Director of Care management will complete an audit of the facility MDS assessments completed over last 90 days to ensure that a comprehensive care plan was developed on 10/27/16. The District Director of Care Management provided re- education with the MDS staff regarding the use of the assessment to develop, review and revise the resident□s comprehensive plan of care on 10/27/16. The e- education also included the coding instructions for V0200C1 and V0200C2	

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F 279	Continued From page 4 bowel and bladder, and received a mechanically-altered diet. The MDS assessment indicated his medications included an antipsychotic and an antidepressant medication. Further review of Resident #5's MDS assessment indicated the following care areas were triggered for an analysis of the findings: Cognitive Loss/Dementia; Visual function; Communication; Urinary Incontinence and Indwelling Catheter; Falls; Nutritional Status; Pressure Ulcer; and, Psychotropic Drug Use. A Care Area Assessment (CAA) Worksheet was completed for each of the care areas triggered. A review of the CAA Worksheets revealed these care areas would be addressed in the resident's care plan. A review of Resident #5's medical record revealed an Interim Care Plan (initiated on 7/18/16) was in place for the resident. A care plan focus area for Falls (dated 7/18/16) and Discharge Potential (dated 7/19/16) supplemented the Interim Care Plan. A comprehensive care plan addressing each of the care areas triggered by the resident's MDS assessment was not available. An interview was conducted on 9/29/16 at 4:55 PM with the facility's MDS Coordinator. The MDS Coordinator reported Resident #5 was admitted to the facility on 7/18/16 and his Admission MDS was completed on 7/25/16. She reported the comprehensive care plan should have been completed by 7/31/16, but it was not. Upon inquiry, the MDS Coordinator reported completion of the resident's comprehensive care plan was unintentionally missed. An interview was conducted on 9/29/16 at 5:45	F 279	utilizing RAI manual V-3 through V6 The District Director of Care Management and or Director of Nursing will complete review of two residents MDS assessment and care plan weekly times four and monthly times two, to ensure that the facility uses the results of assessment to develop, review and revise the resident□s comprehensive plan of care. The Facility Director of Nursing will report finding of the observation to the QAPI committee monthly times three. The committee will review finding and determine if further action is needed The Facility Director of Nursing will report finding of the observation to the QAPI committee monthly times three. The committee will review finding and determine if further action is needed	

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F 279	Continued From page 5 PM with the facility's Director of Nursing (DON). During the interview, the DON stated she was aware the comprehensive care plan had not been completed for Resident #5. A review of the resident's interim care plan and focus areas relating to Falls and Discharge Potential was completed with the DON. When asked if this was a comprehensive, individualized care plan for Resident #5, the DON stated, "No, it's not." A follow-up interview was conducted on 9/29/16 at 7:15 PM with the DON. During this interview, the DON stated, "I would expect the comprehensive care plan be done after the admission assessment by Day 21."	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		10/27/16

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F 329	Continued From page 6 drugs. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to implement a medication dose reduction in accordance with the pharmacist's recommendations and physician's orders for 1 of 3 residents (Resident #2) reviewed for medications. The findings included: Resident #2 was admitted to the facility from a hospital on 10/28/13. Her cumulative diagnoses included schizoaffective disorder (a chronic mental health condition characterized by symptoms of schizophrenia and a mood disorder). Resident #2's most recent Minimum Data Set (MDS) assessment dated 8/29/16 revealed the resident had severely impaired cognitive skills for daily decision making. She was assessed to be totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with bed mobility, dressing, and personal hygiene. Section N of the MDS assessment revealed the resident received an antipsychotic, antianxiety, and antidepressant medication on each of the 7 days during the 7-day look back period. A review of the resident's medical record revealed her medications orders included an order dated	F 329	The facility will continue to strive to ensure that resident□s drug regimen is free form unnecessary drugs. Resident #2 Amantadine dose was changed from 100 mg 2 times daily to 100 mg daily per order. The Director of Nursing and/ or designee will complete audit on 10/27/16 of the facility pharmacists recommends for past ninety days to ensure that recommendation were reviewed and implemented if per physicians orders. The Director of Nursing will provide education to licensed nursing facility regarding implementation of physician approved pharmacist□s recommendations on 10/3/16. Newly hired licensed nurses will receive the education during orientation. Facility licensed staff that does not receive the re- education on 10/3/16 will receive prior to next scheduled shift. The Director of Nursing will review 1-2 random pharmacist recommendation weekly times four, monthly times two, to ensure that approved physician□s pharmacist recommendation has been carried out.	

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F 329	Continued From page 7 8/28/15 for 100 milligrams (mg) amantadine to be given as 1 capsule by mouth twice daily for extrapyramidal symptoms (abnormal involuntary movements). Amantadine is an anti-Parkinson's agent which may be used to treat drug-induced extrapyramidal symptoms. Further review of Resident #2's medical record revealed a Consultation Report from the facility's consultant pharmacist (dated 7/8/16) recommended to decrease the dosing frequency of 100 mg amantadine from twice daily to 100 mg once daily. The pharmacist noted the recommendation was based on manufacturer guidelines for patients with renal impairment, noting Resident #2's estimated creatinine clearance was 28 milliliters per minute (ml/min). The guidelines for adult patients indicated an adjustment of amantadine dosing was required for a creatinine clearance less than 50 ml/min. Resident #2's physician signed the pharmacist's recommendation on 8/30/16. A handwritten notation on the Consultation Report read, "noted 9/8/16 T.O. (Telephone Order) written." The notation was signed by the Assistant Director of Nursing (ADON). A review of Resident #2's medical record revealed a Telephone Order for the decreased dosing of amantadine was not on the chart. A review of the resident's Medication Administration Record (MAR) for September 2016 revealed 100 mg amantadine continued to be administered twice daily through 9/28/16. A telephone interview was conducted on 9/29/16 at 3:10 PM with Resident #2's Medical Doctor (MD). During the interview, the MD stated she	F 329	The Facility Director of Nursing will report finding of the observation to the QAPI committee monthly times three. The committee will review finding and determine if further action is needed.	

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was not sure what happened with the paperwork after the reduction in dosing was signed as an order. She noted sufficient time had elapsed where this order should have been changed. The MD reported that although this may not have been a critical medication error, it was an important one.

An interview was conducted on 9/29/16 at 3:30 PM with the facility's ADON. During the interview, the ADON reported she would review the resident's medical record regarding the dose reduction of amantadine for Resident #2.

An interview was conducted on 9/29/16 at 3:55 PM with the facility's Unit Supervisor. The Unit Supervisor reported the Telephone Order for Resident #2 ' s amantadine dose reduction was written on 9/8/16 by the ADON. However, she stated the Telephone Order had been misplaced and the order did not get transcribed onto the MAR. The Unit Supervisor reported she had just called the resident's MD to inform her of the medication error and was in the process of completing a Medication Variance (error) Report.

An interview was conducted on 9/29/16 at 4:30 pm with the facility's Director of Nursing (DON). During the interview, the DON reported the facility's process of communicating the pharmacist's consultation reports and subsequent physician's orders needed to be changed. She stated that once the pharmacist consultations became available, they would go straight to the MD's office. The DON indicated she would expect the facility to implement new physician orders within 24 hours after the pharmacist's consultation had been reviewed, signed, and returned by the physician.

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to administer medications within an appropriate and clinically significant time frame in accordance with physician's orders and medication recommendations for 2 of 6 sampled residents (Residents #2 and #6) reviewed for medication administration. The findings included: 1) Resident #2 was admitted to the facility from a hospital on 10/28/13. Her cumulative diagnoses included hypothyroidism. Resident #2's most recent Minimum Data Set (MDS) assessment dated 8/29/16 indicated she had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring extensive assistance with bed mobility, dressing, and personal hygiene. A review of Resident #2's medical record included a medication order from 8/4/16 to 9/15/16 for 112 micrograms (mcg) levothyroxine (a thyroid hormone replacement medication) to be given as one tablet by mouth in the morning. The medication was scheduled for 8:00 AM each morning. According to Lexi-Drugs, a	F 333	The facility will continue to strive to ensure that residents are free of any significant medication errors. Resident #2 attending physician was notified on 9/29/16 that resident Levothyroxine 112 mcg was given outside the acceptable time frame by DON Resident #6 attending physician was notified on 9/29/16 that resident Carbidopa/levodopa 25mg/100mg was given outside the acceptable time frame by DON. The facility Director of Nursing/designee will review the medication records facility residents for 9/29/16 to ensure that each resident□s medication was not given outside the acceptable time frame. The Director of Nursing will provide education to licensed nurses and CMAs regarding timely medication administration, to include acceptable time frames on 9/30/16. Newly hired direct care staff will receive the education during orientation. Facility staff that does not receive the re- education on 9/30/16 will receive prior to working next scheduled shift. The Director of Nursing and/or ADON will complete two medication pass observation weekly times four, monthly	10/27/16

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comprehensive drug database, levothyroxine should be administered in the morning on an empty stomach, at least 30 to 60 minutes before food.

Further review of Resident #2's medical record revealed laboratory results reported on 9/15/16 included a Thyroid Stimulating Hormone (TSH) level of 5.24 (noted as high). Normal values for a TSH level range from 0.4 to 4.0 milli-international units per liter. A high TSH level may mean the resident was receiving too little thyroid hormone replacement medication. Handwritten notations on the report (dated 9/16/16) indicated the resident was receiving 112 mcg levothyroxine and noted levothyroxine would be increased to 125 mcg daily. A request was made to recheck the resident's TSH level in 6 weeks.

On 9/16/16, a physician's order was received to change Resident #2's levothyroxine to 125 mcg to be given as one tablet by mouth in the morning. The medication was scheduled for 8:00 AM each morning.

On 9/29/16 at 10:54 AM, Medication (Med) Aide #1 was observed standing next to the medication cart in front of Resident #2's room. Med Aide #1 reported she was ready to begin preparing medications for administration to the next resident. Upon inquiry, Med Aide #1 acknowledged she had just finished administering medications to Resident #2, which included the levothyroxine scheduled for administration at 8:00 AM.

A follow-up interview was conducted on 9/29/16 at 2:47 PM with Med Aide #1. Upon inquiry, the med aide confirmed she completed her

times two.
The Facility Director of Nursing will report finding of the observation to the QAPI committee monthly times three. The committee will review finding and determine if further action is needed.

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medication pass at 11:20 AM this morning, which included medications scheduled for 8:00 AM and 9:00 AM administration. When asked, Med Aide #1 reported it was expected that medications would be given within one hour of their scheduled time for administration. The med aide stated she could typically meet this goal when assigned to pass medications on only one hall. However, she acknowledged the morning med pass was usually completed at 11:00-11:30 AM on days (such as today) when she was assigned to pass medications on more than one hall.

A telephone interview was conducted on 9/29/16 at 3:10 PM with Resident #2's Medical Doctor (MD). During the interview, the MD was asked what her thoughts were in regards to Resident #2 receiving levothyroxine just before 10:54 AM, instead of the scheduled administration time of 8:00 AM. In response, the MD stated the levothyroxine should actually have been rescheduled for administration during an earlier medication pass at 6:00 AM or 7:00 AM at the facility. She indicated it was not appropriate to administer the levothyroxine late in the morning.

An interview was conducted on 9/29/16 at 4:30 PM with the facility's Director of Nursing. When asked, the DON stated her expectation was for the levothyroxine to be given, "by eight o ' clock," if it was scheduled for 8:00 AM because she knew it was supposed to be given on an empty stomach.

A telephone interview was conducted on 9/29/16 at 5:10 PM with the facility's consultant pharmacist. Upon discussion of Resident #2's levothyroxine administration, the pharmacist stated, "It should be given at 8:00 AM."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHABILITATIO	647 S RAILROAD STREET BOX 966 WALLACE, NC 28466

(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
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2) Resident #6 was admitted to the facility from a hospital on 8/31/14. Her cumulative diagnoses included Parkinson's disease.

Resident #6's most recent Minimum Data Set (MDS) assessment dated 8/30/16 indicated she had moderately impaired cognitive skills for daily decision making. The resident required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for locomotion on/off the unit, dressing, eating, and bathing.

A review Resident #6's medical record revealed the resident's current medication orders included an order for 25 milligrams (mg) / 100 mg carbidopa / levodopa (a combination medication used for the treatment of Parkinson ' s disease) to be given as one tablet three times daily. The medication was scheduled for administration at 8:00 AM, 4:00 PM, and 10:00 PM every day.

According to Lexi-Drugs, a comprehensive drug database, the half-life elimination of levodopa in the presence of carbidopa is 1.5 hours. The half-life is the amount of time necessary for the concentration of the drug in the bloodstream of the body to be reduced by one-half. Carbidopa / levodopa works best when there is a constant amount in the blood. Therefore, according to Lexi-Drugs, carbidopa / levodopa should be administered with the doses spaced evenly over the waking hours; and, the medication should be administered with meals to decrease GI upset.

On 9/29/16 at 10:54 AM, Medication (Med) Aide #1 was observed as she prepared medications for administration to Resident #6. The

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	345323	A. BUILDING _____ B. WING _____	C 09/29/2016

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medications included one-25 mg / 100 mg carbidopa / levodopa tablet.

An interview was conducted on 9/29/16 at 2:47 PM with Med Aide #1. Upon inquiry, the med aide confirmed she completed her medication pass at 11:20 AM this morning, which included medications scheduled for 8:00 AM and 9:00 AM administration. When asked, Med Aide #1 reported it was expected that medications would be given within one hour of their scheduled time for administration. The med aide stated she could typically meet this goal when assigned to pass medications on only one hall. However, she acknowledged the morning med pass was usually completed at 11:00-11:30 AM on days (such as today) when she was assigned to pass medications on more than one hall.

A telephone interview was conducted on 9/29/16 at 3:10 PM with Resident #6's Medical Doctor (MD). During the interview, the MD was asked what her thoughts were in regards to Resident #6 receiving the first of three doses of carbidopa / levodopa at 10:54 AM, instead of the scheduled administration time of 8:00 AM. In response, the MD stated, "You and I both know that's not how med pass is supposed to happen."

An interview was conducted on 9/29/16 at 4:30 PM with the facility's Director of Nursing. When asked what the DON ' s expectation was in regards to the timing of the carbidopa / levodopa administration for Resident #6, the DON stated, "I ' m thinking that's not when it should have been given." She indicated medications should be given within one hour of their scheduled time for administration.

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F 333	Continued From page 14 A telephone interview was conducted on 9/29/16 at 5:10 PM with the facility's consultant pharmacist. Upon discussion of the timing for Resident #6's carbidopa / levodopa administration, the pharmacist stated, "That is a concern."	F 333		