DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING ______ B. WING ______	C 12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY ROAD CLAYTON, NC 27520

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F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interviews the facility failed to administer a pain medication for one (Resident #2) of four sampled residents and medications on admission date for two (Resident #2 and #3) of four sampled residents. The findings included: Record review revealed Resident # 2 was admitted to the facility on 11/17/16 after being hospitalized for respiratory failure secondary to heart failure. Record review revealed the resident had additional diagnoses of kidney disease and diabetic neuropathy. Review of the resident ' s admission MDS (Minimum Data Set) assessment, dated 11/30/16, revealed the resident was assessed to have a BIMS (Brief Interview for Mental Status) of 15. This indicated the resident was cognitively intact. The resident was interviewed on 12/20/16 at 8:35 AM and stated she took Percocet twice per day for neuropathy pain. The resident stated she had taken the Percocet for about four years prior to her facility residency. The resident stated since she had resided in the facility, there were times she had not received the Percocet. The resident stated she had been told they did not have the pain medication at times and at other times it had not been in her medication cup. The resident also stated on the day of her facility admission she	F 281	F281 1. Physician was notified on 12/21/2016 for residents #2 and #3 regarding missed meds. No new orders were received at that time. Facility residents have the potential to be affected by this alleged deficient practice. All resident orders were verified to ensure medications were present in the facility to be given as ordered on 12/22/2016. 2. Licensed Nurses will be educated to notify Pharmacy of new admission arrivals and request all medications to be sent, including faxing hard scripts of all controlled substances. If meds are not received by the time medications are to be administered, nurses will notify physician and DON for further guidance. Licensed Nurses were educated on the procedure for signing out controlled substances from the Back Up / Emergency Kit including signature on the log to remove the medication as well as signing of the MARs. Audit of Back Up / Emergency Kit was completed to ensure accuracy of contents.	1/16/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/11/2017

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 281	Continued From page 1 had not received all of her scheduled medications. Review of the resident ' s hospital discharge summary, dated 11/17/16, revealed the resident was ordered to receive Percocet 10-325 mg (milligrams) twice per day on a routine schedule. Review of the resident ' s facility record revealed the Percocet order was entered into the facility computer system as an order at 1 PM on the resident ' s admission date of 11/17/16. Review of the resident ' s November 2016 MAR (medication administration record) revealed the resident ' s 9 PM Percocet dose on 11/17/16 was not given. A number " 8 " appeared on the electronic MAR at this administration time. According to the MAR a number " 8 " signified a progress note had been made. Review of the progress notes revealed an entry on 11/17/16 at 8:32 PM by Nurse # 1 that the medication was not available. There was no documentation the resident received the Percocet at a later time on 11/17/16. Following the 11/17/16 admission date, the first time the resident was documented as receiving the Percocet was on 11/18/16 at 9 PM. Review of Resident # 2 ' s hospital discharge summary, dated 11/17/16, revealed the resident was ordered to receive Ranolazine 500 mg (a 12 hour tablet) two times per day. Review of the resident ' s facility record revealed the Ranolazine order was entered into the facility computer system as an order at 1 PM on the resident ' s admission date of 11/17/16. The diagnosis entered beside the order was chronic kidney disease. Review of the resident ' s November 2016 MAR revealed the resident ' s 9 PM Ranolazine dose on 11/17/16 was not given. A number " 8 " appeared on the electronic MAR at this administration time. Review of the progress notes revealed an entry on 11/17/16 at 8:32 PM	F 281	3. Physician□s orders from previous day will be reviewed by Nursing Department daily to ensure medications were received and administered as ordered. The Director of Nursing or designee will audit the Back Up / Emergency Kit sign out process weekly x 4 weeks and randomly thereafter. 4. The Director of Nursing will report findings to QAPI committee for three months. Data will be reviewed and analyzed for possible patterns and trends. QAPI committee to evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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F 281	Continued From page 2 by Nurse # 1 that the medication was not available. There was no documentation the resident received the Ranolazine at a later time on 11/17/16. The first documented time the resident received the Ranolazine was on 11/18/16 at 9 AM. Review of Resident # 2 ' s hospital discharge summary, dated 11/17/16, revealed the resident was ordered to receive 2.5 % Anusol-HC rectal cream two times per day. Review of the resident ' s facility record revealed the Anusol order was entered into the facility computer system as an order at 1 PM on the resident ' s admission date of 11/17/16. Review of the resident ' s November 2016 MAR revealed the resident ' s 9 PM Anusol dose on 11/17/16 was not given. A number " 8 " appeared on the electronic MAR at this administration time. Review of the progress notes revealed an entry on 11/17/16 at 8:32 PM by Nurse # 1 that the medication was not available. There was no documentation the resident received the Anusol at a later time on 11/17/16. The first documented time the resident received the Anusol cream was on 11/18/16 at 9 AM. Nurse # 1 was interviewed on 12/21/16 at 9:40 AM. Nurse # 1 stated if she had documented the medications were not available then this meant that the medications had not been delivered by the pharmacy. The nurse stated she routinely checked for the medication delivery and called the pharmacy before she documented a medication was not available, but if it was not available she would not have been able to administer the medications. A pharmacist was interviewed on 12/20/16 at 4:15 PM. The pharmacist stated they had not received a faxed Prescription for the Percocet on 11/17/16. The pharmacist stated, per regulations, initial narcotic orders could not be transferred	F 281		

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F 281	Continued From page 3 electronically to the pharmacy and thus they would not have seen the order when it was placed in the facility ' s computer system. The pharmacist stated they would not have known the Percocet needed to have been filled and thus it was not sent to the facility nor was a prompt sent to the facility reminding them to send a prescription so it could be filled. The pharmacist stated the first date they received a prescription for the Percocet and filled the Percocet was on 11/19/16, which was two days after the resident ' s admission date. The pharmacist stated the facility could have obtained a physician ' s permission to substitute a medication when they charted they gave the Percocet on 11/18/16 at 9 PM since they would not have received the medication by that date. The pharmacist stated they filled the Ranolazine on 11/17/16 and their records showed the Ranolazine arrived in the facility at 9:24 PM. The pharmacist stated they did not fill orders for Anusol H-C cream and this would have been ordered by the facility as a stock medication. The administrator and DON (Director of Nursing) were interviewed on 12/20/16 at 5 PM. The DON stated she thought the Percocet prescription had not been sent with the resident upon admission, and this contributed to the resident not getting the Percocet on admission date. The DON and administrator stated they thought the pharmacy would have questioned the missing prescription when they saw the computer order entered. Neither the DON nor administrator was aware the pharmacy was not receiving new narcotic orders electronically. The DON stated the Anusol was not anything the facility kept in stock and they would have had to have ordered it as a stock medication. Review of Resident # 2 ' s November MAR	F 281		

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F 281	Continued From page 4 revealed the resident was not documented as receiving her morning dose of Percocet on 11/18/16 (the day following admission.) Review of the progress notes revealed an entry by Nurse # 2 on 11/18/16 at 2:43 PM that the pharmacy was contacted and the order was revised. Following the 11/17/16 admission date, the first time the resident was documented as receiving the Percocet was on 11/18/16 at 9 PM. Nurse # 2 was interviewed on 12/20/16 at approximately 2:45 PM. Nurse # 2 stated as she recalled the Percocet prescription had been faxed into the pharmacy but the medication had not been sent when the resident was admitted so that it could be administered. Nurse # 2 stated she contacted the pharmacy on 11/18/16 and was told the pharmacy could not see the order in the computer system. The nurse stated she was told to re-enter the order and thus re-entered the order as Oxycodone-Acetaminophen tablet 10-325 mg twice per day. The nurse stated it was the same medication order but written in a different way. Interview with the pharmacist on 12/20/16 at 4:15 PM revealed a different computer order entry would not have made a difference in the pharmacy being able to fill the prescription. The pharmacist stated all initial narcotic orders are blocked electronically from coming through to their system and they require the initial prescription to fill a narcotic order. The pharmacist stated there was no notation in their system the facility had called and talked to them on 11/18/16 about the Percocet. Resident # 2 ' s December 2016 MAR was also reviewed. On 12/10/16 at 8 PM Nurse # 3 documented she administered Percocet 10-325 mg. By regulations, a nurse must sign for the removal of Percocet from a locked storage area	F 281		

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and these records maintained. Record review revealed nurses were signing for the removal of the Percocet on a form entitled " controlled medication utilization record. " Review of Resident # 2 ' s Percocet controlled medication utilization record revealed no documentation the nurse removed the Percocet on 12/10/16 at 8 PM in order to administer the medication.
Nurse # 3 was interviewed on 12/21/16 at 12:30 PM. Nurse # 3 stated although she had documented she had administered the medication she had not done so because the resident had refused the medication. The nurse stated she should have documented the refusal instead of the administration.
Resident # 2 was interviewed again on 12/21/16 at 12:45 PM. The resident stated she had never refused taking her Percocet because she really needed it for her neuropathy.
Review of Resident # 2 ' s December 2016 MAR revealed on 12/13/16 at 8 PM Nurse # 4 documented that she administered Percocet 10-325 mg. Review of the resident ' s Percocet controlled medication utilization record revealed no documentation the nurse removed the Percocet on 12/13/16 at 8 PM in order for it to be administered.
Interview with the DON on 12/20/16 at 2 PM revealed she had contacted Nurse # 4 on 12/20/16 and the nurse could not recall where she would have gotten the medication in order to administer it. The DON stated the facility did not keep Percocet 10-325 mg in their narcotic back-up supply. The DON stated she had checked and found no other place the nurse could have obtained the drug in order to have administered it on 12/13/16.
2. Record review revealed Resident # 3 was admitted to the facility on 11/26/16 which

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F 281	Continued From page 6 corresponded to a Saturday. Record review revealed Resident # 3 had diagnoses of Parkinson ' s, mild dementia, diabetic neuropathy. Review of the resident ' s 11/26/16 hospital discharge summary revealed the resident was ordered to receive carbidopa-levodopa 25-100 mg (milligrams) four times per day for her Parkinson ' s disease. According to the hospital records, located on the resident ' s facility record, the resident last received this medication on 11/26/16 at 6:03 AM prior to her transfer to the facility. Review of the resident ' s facility record revealed the carbidopa-levodopa order was entered into the facility computer system as an order at 12:43 PM on the resident ' s admission date of 11/26/16. The administration times were placed on the electronic MAR as 2 PM; 6 PM; and 10 PM. There was no documentation the carbidopa-levodopa was administered on 11/26/16. Review of the progress notes revealed an entry by Nurse # 5 on 11/26/16 at 7 PM that the medication was on order. The first documented time the resident received the Carbidopa-Levodopa was on 11/27/16 at 10 AM. Review of the resident ' s 11/26/16 hospital discharge summary revealed the resident was ordered to receive Gabapentin 800 mg four times per day for her neuropathy pain. Review of the resident ' s facility record revealed the order was entered into the facility computer system as an order at 12:43 PM on the resident ' s admission date of 11/26/16. The administration times were placed on the electronic MAR as 10:00 AM; 2 PM; 6 PM; and 10 PM. There was no documentation the Gabapentin was administered on 11/26/16. Review of the progress notes revealed an entry by Nurse # 5 on 11/26/16 at 7:08 PM that the medication was on order. The first documented time the resident received the	F 281		

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F 281	Continued From page 7 Gabapentin was on 11/27/16 at 10 AM. Review of the resident ' s 11/26/16 hospital discharge summary revealed the resident was ordered to receive donepezil 5 mg every night for five nights. Review of the resident ' s facility record revealed the order was entered into the facility computer system as an order at 1:53 PM on the resident ' s admission date of 11/26/16. There was no documentation the donepezil was administered on 11/26/16. Review of the progress notes revealed an entry by Nurse # 5 on 11/26/16 at 9:04 PM that the medication was on order. The first documented night the resident received the donepezil was on 11/27/16 at 9 PM. Nurse # 5 was interviewed on 12/20/16 at 3:25 PM. Nurse # 5 stated if the medication was not in the facility to administer then she documented this in the resident ' s record. The nurse stated sometimes the pharmacy did not send new medications and they would have to call the pharmacy. The nurse stated sometimes it was harder to get medications on Saturday than through the week. The nurse stated sometimes the pharmacy would send the medications but it also depended on which pharmacist they talked to. The nurse stated some of the pharmacist would tell the facility they would send medications on the " next run. " Interview with a pharmacist on 12/20/16 at 4:15 PM revealed they received the Carbidopa-levodopa medication order and the Gabapentin order at 1:19 PM and per their documentation it was sent to the facility at 8:06 PM. The pharmacist stated they needed a three hour " turn around " time to get the medication to the facility but if the facility had called then the pharmacy could have reasonably gotten Resident # 3 ' s medications to them by 6 PM dose times. The pharmacist stated Carbidopa-levodopa was	F 281		

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F 281	Continued From page 8 an important Parkinson ' s medication to keep on a schedule. The pharmacist stated they had no record of ever filling the donepezil on 11/26/16.	F 281		