STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HLTH & REHAB BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interviews the facility failed to accurately code the	F 278	"Preparation and/or execution of this plan of correction does not constitute	2/22/17

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

Electronically Signed | 02/17/2017

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F 278	Continued From page 1 quarterly Minimum Data Set (MDS) assessment for 1 out of 4 sampled residents (Resident #3). Findings included: Resident #3 was admitted to the facility on 4/29/15 with a diagnosis of vascular dementia, psychotic disorder and heart failure. A quarterly Minimum Data Set (MDS) dated 12/26/16 indicated Resident #3 did not receive Hospice care while a resident. Record review revealed a clarification order signed by the doctor on 10/20/16 that indicated Resident #3 was admitted to Hospice care on 8/10/16. Record review further revealed Hospice notes that indicated Resident #3 had received Hospice visits in facility on 12/21/16 and 12/22/16. During an interview on 2/1/17 at 11:55 AM the MDS Nurse indicated Resident #3 was currently on Hospice and had received Hospice services in December 2016. The MDS Nurse went on to say the quarterly MDS dated 12/26/16 was coded inaccurately and should have been coded to have received Hospice services. The MDS Nurse indicated a modification MDS would be completed. On 2/1/17 at 4:00 PM the Administrator stated her expectations were for the MDS for Resident #3 to be coded accurately and to reflect the current status of the resident.	F 278	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law." 1. Corrective action was accomplished for alleged deficient practice in regard to resident #3's MDS by correcting Section O. 2. All residents have the potential to be affected by the alleged deficient practices. Measures put into place to ensure the alleged deficient practice does not re-occur include: Director of Nursing educated Resident Care Management Director on accurate coding of section O on the MDS. 3. All current residents on Hospice will be audited to verify accurate coding of Section O on the MDS. DON/ADON will audit 3 MDS Section O weekly x1 month to verify accuracy, then 3 MDS's every other week x 2 months. 4. Results of the audits will be reported by the Director of Nursing in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further recommendations as indicated.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		2/22/17

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F 514	Continued From page 2 (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interviews the facility failed to record administration of a prescribed narcotic medication on the Medication Administration Record for 2 of 3 residents (Resident #1 and #2) reviewed for	F 514	"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	

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F 514	Continued From page 3 medications. Findings included: 1. Resident #1 was readmitted to the facility on 12/14/16 with diagnosis of cirrhosis of the liver. The significant change Minimum Data Set (MDS) indicated the resident was moderately cognitively impaired, and received Hospice care while a resident. Record review revealed a doctor's order for Resident #1, dated 1/1/17, for Morphine Sulfate (a pain medication) give 10 milligrams (mg) by mouth every 1 hour as needed (PRN) for pain or shortness of breath. The narcotic sheet for Resident #1 revealed Morphine Sulfate 10mg was given on 1/1/17 by Nurse #1 at 4:45 PM, 5:45 PM, and 6:45 PM. The January 2017 Medication Administration Record (MAR) did not indicate Resident #1 had received Morphine Sulfate 10mg at 4:45 PM, 5:45 PM, and 6:45 PM on 1/1/17. During an interview on 2/1/17 at 3:10 PM, Nurse #1 indicated she did not believe she missed documenting the PRN Morphine for Resident #1 on 1/1/17 on the MAR but she could not swear to it. Nurse #1 went on to say she did document on the Narcotic sheet for PRN Morphine on 1/1/17 at 4:45 PM, 5:45 PM, and 6:45 PM. During an interview on 2/1/17 at 3:30 PM, The Director of Nursing (DON) indicated Nurse #1 did not document the PRN Morphine on the MAR for Resident #1 on 1/1/17 at 4:45 PM, 5:45 PM, and 6:45 PM. The DON further stated the nurses were supposed to document PRN medications on the MAR when given. The DON indicated she expected for the documentation for PRN medications on the MAR and narcotic sheet to be correct. On 2/1/17 at 4:00 PM the Administrator stated her expectations would be for the documentation of	F 514	deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law." 1. Corrective action was accomplished for the alleged deficient practice in regard to resident's #1 and #2 by completing medication variance reports related to transcription error. 2. All residents have the potential to be affected by the alleged deficient practice therefore, Nurse #1 and Nurse #2 were re-educated on appropriate documentation for prn narcotic medication administration. All licensed nurses will be re-educated on appropriate transcription of prn narcotic medications to include documentation on the narcotic declining form as well as transcription into the electronic medication administration record. 3. An audit will be completed on current residents receiving prn narcotics in the past 30 days. DON/Nurse Managers will audit 10 residents receiving prn narcotics weekly x4 weeks, then 10 every other week x2 months to ensure appropriate documentation to include documentation on the narcotic declining form as well as transcription into the electronic medication administration record. 4. Results of the audits will be reported by the Director of Nursing in the monthly QAPI meeting x3 months. The QAPI committee will evaluate and make further	

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F 514	Continued From page 4 PRN medications to be accurate and complete on the MAR and narcotic sheets. The Administrator indicated that she expected for the narcotic sheet and the MAR to match. 2. Resident #2 was admitted to the facility on 1/26/16 with diagnosis of dementia. The significant MDS dated 12/2/16 indicated the resident was severely cognitively impaired. Record review revealed a doctor's order for Resident #2, dated 1/5/17, for Morphine Sulfate 10 milligrams (mg) every 1 hour PRN for pain or shortness of breath. The narcotic sheet for Resident #2 revealed Morphine Sulfate 10mg given on 1/5/17 at 10:30 AM and 11:30 AM. The MAR dated 1/5/17 did not indicate Resident #2 to have received Morphine Sulfate 10mg at 10:30 AM and 11:30 AM. During an interview on 2/1/17 at 2:57 PM, Nurse #2 indicated she documented the PRN Morphine for Resident #2 on the MAR and the narcotic sheet on 1/5/17. Nurse #2 went on to say she always tried to remember to document the PRN medications on the MAR. During an interview on 2/1/17 at 3:30 PM, The Director of Nursing (DON) indicated Nurse #2 did not document the PRN Morphine on the MAR for Resident #2 on 1/5/17 at 10:30 AM and 11:30 AM. The DON further stated the nurses were supposed to document PRN medications on the MAR when given. The DON indicated she expected for the documentation for PRN medications on the MAR and narcotic sheet to be correct. On 2/1/17 at 4:00 PM the Administrator stated her expectations would be for the documentation of PRN medications to be accurate and complete on the MAR and narcotic sheets. The Administrator indicated that she expected for the narcotic sheet	F 514	recommendations as indicated.	

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F 514	Continued From page 5 and the MAR to match.	F 514		