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	345080	A. BUILDING _____ B. WING _____	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 No deficiencies cited as result of the complaint investigation. Event ID# C78I11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #81) and in the area of discharge location for 1 of 3 sampled residents (Resident #83) for closed record review. Findings Included: 1. Resident #81 was admitted to the facility on 12/11/17 with diagnoses that included degenerative disease of basal ganglia, Alzheimer's disease, Parkinson's disease, cognitive communication deficit, vascular dementia, unspecified dementia with behavioral disturbance and anxiety disorder among others. A review of Resident #81's most recent Minimum Data Set (MDS) Assessment dated 07/03/18 and coded as a quarterly revealed Resident #81 to be cognitively impaired and required extensive assistance with all Activities of Daily Living. Further review of Resident #81's quarterly MDS revealed he was coded as "Antipsychotics were not received".	F 641	F641 - Accuracy of Assessments Criteria #1 - The plan of correcting cited deficiency of F641 and the processes that lead to the citation; The facility will accurately reflect discharge status of residents on the MDS. The plan for correcting the cited deficiency is that the facility will ensure that discharge status of residents will be accurately coded on the MDS. The process failure occurred because staff pushed the wrong button on the computer. Criteria #2- The procedure for implementing the plan of correction for F641; On 8/7/18 the MDS staff was re-inserviced on MDS accuracy by the District Director Care Management(DDCM)related to antipsychotic medications and discharge to the community.	8/10/18

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

Electronically Signed | 08/08/2018

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F 641	Continued From page 1 A review of electronic physician orders on 07/17/18 revealed a physician order for RisperDAL tablet 0.5mg, an antipsychotic, at a dose of 1 tablet at bedtime for dementia with psychosis. A review of Resident #81's medication administration record (MAR) revealed Resident #81 received multiple doses of RisperDAL during the time observed for completion of the quarterly MDS assessment dated 07/03/18. During an interview with MDS Nurse #1 on 07/19/18 at 11:26 AM, it was revealed that the section of the assessment where it was coded that Resident #81 did not receive antipsychotics was coded wrong. She stated she "just coded it wrong" and Resident #81's MDS should show that he had received antipsychotics during the assessment look back period. She had no other explanation other than she checked the wrong answer. She reported at this time she would fix the error and resend the assessment. An interview with the Administrator on 07/19/18 at 11:40 AM revealed it was his expectation that they (MDS Nurses) do the best they could "but that there would be human error" at times. He further stated he expected MDS assessments to be correct. 2. Resident #83 was admitted to the facility on 05/15/18 with diagnoses that included pneumonia. Review of the discharge summary dated 05/23/18 specified Resident #83 planned to discharge to a private residence.	F 641	The Resident Care Management Director(RCMD)or designee will monitor resident discharge records to the community for accuracy and for antipsychotics. The MDS coordinator will monitor the RCMD. Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria #3 - The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following: The RCMD or designee will complete weekly audits of MDS discharge status by reviewing all discharged resident's records and antipsychotic medications for twelve (12) weeks to ensure the plan of correction is effective and remains in compliance with the regulatory requirements. Results will be reported to monthly QAPI meeting. The QAPI committee will determine the need for further auditing after the initial twelve (12) weeks. Criteria #4 - The person responsible for implementing the plan of correction. The RCMD is responsible for implementing the corrective action.	

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F 641	Continued From page 2 A physician's order dated 05/24/18 read in part the resident was cleared to discharge home on 05/26/18. A nurses' progress noted date 05/26/18 specified the resident discharged home with family, discharge instructions and prescriptions were provided to the resident and son. Resident #83's discharge MDS assessed dated 05/26/18 specified the resident was discharged to an acute hospital. On 07/17/18 at 3:41 PM MDS Coordinator #1 was interviewed. She reviewed Resident #83's discharge MDS and stated she completed the MDS. She explained that it was her practice to review discharge notes and physician orders to determine a resident's discharge location. In the case of Resident #83, she reviewed the medical record and stated the MDS was coded wrong as result of oversight.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		8/10/18

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F 761	Continued From page 3 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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 observations, record review, and staff interviews, the facility failed to discard 3 unopened boxes of expired medications from 1 of 1 medication room. The findings included: Observation of the medication room on 07/18/18 at 4:00PM revealed 3 expired boxes of Albuterol-Ipratropium Inhalation Solution on the shelf, available for use. 2 boxes of the medications had expiration dates of May 2018 and 1 box had an expiration date of June 2018. The pharmacy labels stated the medications were prescribed for Resident #35. The Director of Nursing (DON) was present during observation of the medication room and verified the expiration dates on the medications. She stated all nursing staff are responsible for checking dates on medications and discarding any expired or discontinued medications but that she had been the person rotating, organizing, and checking stock medications for expiration	F 761	F761 - Label/Storage Drugs and Biologicals Criteria #1-The plan of correcting cited deficiency of F761 and the processes that lead to the citation; The facility plan is that all medications and biologicals are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents or visitors. All required medications and biological will have an opened date or expiration date label on the medication and that all discontinued or expired medications will be removed from use from the medication cart or refrigerator. The process failure occurred when staff members failed to return to pharmacy, expired medication opened leaving the vial without an expiration date. Criteria # 2 - The procedure for implementing the plan of correction for	

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F 761	Continued From page 4 consistently. She further added, the expired medications prescribed for Resident #35 had been discontinued which is why the boxes were unopened and likely how they became pushed to the back behind the other medications. An interview with the DON on 07/19/18 at 3:35PM revealed her expectations were that medications in the medication room would be in date, expired medications would be discarded, and discontinued medications would be returned to the pharmacy immediately.	F 761	F761; On August 2, 2018 staff were re-educated by the Director of Nursing on Medication Administration in the facility which included expired medications. Director of Nursing and Assistant Director of Nursing met with Omnicare pharmacy on August 1, 2018 to ensure medications are being checked by nurses and pharmacy. An Inservice on August 8, 2018 on expired medications including disposing of all expired medications was completed by the Director of Nursing. The Charge Nurse will audit medication storage room for discontinued and expired medications three (3) times a week for twelve (12) weeks for any opened, undated medications and expired medications. The Charge nurse will remove all medications from medication carts and return to pharmacy three (3) times a week. The pharmacy will complete monthly random audits to verify process is working and report all findings to the Director of Nursing. Criteria#3- The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following:	

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F 761	Continued From page 5	F 761	The Director of Nursing will review expired medications audits completed by the unit managers every week and follow-up on any trends or patterns. The Director of Nursing will report results to the QAPI committee monthly. The QAPI committee will determine the need for further monitoring after the initial twelve weeks. Criteria #4- The person responsible for implementing the plan of correction. The Director of Nursing is responsible for implementing the corrective action.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		8/10/18

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F 812	Continued From page 6 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to remove expired food from use for 1 of 1 observation in the kitchen's walk-in cooler. The findings included: On 07/16/18 at 2:09 PM an initial tour of the kitchen was made with the Dietary Manager (DM). The DM explained he was new in his role. The walk-in cooler was observed and noted to have the following outdated food: - Four 32-ounce cartons of liquid eggs stamped with an expiration date of 07/11/18 - Unlabeled lunch meat dated 06/06/18 - Two packs of liver mush with the use by date of 07/01/18 During the observations, the DM was interviewed and reported the morning cook was responsible for daily checks to remove all outdated food. He added that he also checked the leftover foods and offered no explanation why the expired food was stored for use.	F 812	F812 - Food Procurement, Store/Prepare/Serve Sanitary Criteria #1 - The plan of correcting cited deficiency of F812 and the processes that lead to the citation. The facility will ensure that any outdated food will be thrown away. The plan for correcting the cited deficiency is that the facility will check daily any outdated food in the cooler. The process failure occurred because staff did not ensure the outdated food was thrown away. Criteria #2 - The procedure for implementing the plan of correction for F812; On August 8,2018 Dietary Staff was inserviced on outdated foods and procedure to ensure that no outdated food was left in the facility by the District Area Certified Dietary Manager. Results will be discussed during morning meeting and any negative concerns will be addressed promptly. Criteria #3 - The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following:	

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F 812	Continued From page 7	F 812	The Dietary Manager of Designee will complete weekly audits for any outdated foods for 12 weeks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. Results will be reported to monthly QAPI meeting. The QAPI committee will determine the need for further auditing after the initial 12 weeks. Criteria #4- The person responsible for implementing the plan of correction. The Dietary Manager is responsible for implementing the corrective action.	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions.	F 865		8/10/18

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F 865	Continued From page 8 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in June 2017. This was for 3 recited deficiencies originally cited in June 2017 on an annual recertification survey. The deficiencies were in the areas of MDS Accuracy, Kitchen Sanitation and Drug Storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Committee. The findings included: F 641: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #81) and in the area of discharge location for 1 of 3 sampled residents (Resident #83) for closed record review. F 483.20: Cited in June 2017 for failing to code a diagnosis. F 761: Based on observations, record review, and staff interviews, the facility failed to discard 3 unopened boxes of expired medications from 1 of 1 medication room. F 483.45 Cited in June 2017 for leaving a medication unattended at the nurses' station and expired medications.	F 865	F865 - QAPI/QAA Improvement Activities Criteria #1 - The plan of correcting cited deficiency of F865 and the process that lead to the citation; The facility will ensure that it has an effective QAPI Committee. The plan for correcting the cited deficiency is that the facility has secured a new Permanent Director of Nursing, Assistant Director of Nursing and Dietary Manager. Criteria #2 - The procedure for implementing the plan of correction F865; On August 9, 2018 the QAPI Committee will be inserviced on the new QAPI process and expectations by the District Director Clinical Services (DDCS). The Administrator and the Medical Director will monitor the QAPI process. Results will be discussed during QAPI and morning meeting and any negative concerns will be addressed promptly. Criteria #3 - The monitoring procedure to ensure that the plan of correction is effective and that the deficiency remains corrected and/or in compliance with the regulatory requirements include the following:	

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F 865	Continued From page 9 F 812: Based on observations and staff interview, the facility failed to remove expired food from use for 1 of 1 observation in the kitchen's walk-in cooler. F 483.60 Cited in June 2017 for storing soiled meal trays with clean meals trays for a lunch observation. On 07/19/18 at 3:23 PM the Administrator was interviewed and reviewed the facility's Quality Assurance Program. He explained the team met monthly. He added an agenda was followed that included reviewing compliance with previous citations from surveys. The Administrator stated he felt the facility was in compliance with the previous citations and was unaware of ongoing issues related to MDS accuracy, Drug Storage or Kitchen Sanitation.	F 865	The Administrator or designee will review weekly audits for F641, F761, F812, and F865 for twelve (12) weeks to ensure the plan of correction is effective and remains in compliance with the regulatory requirement. Results will be reported to monthly QAPI meeting. Criteria #4 - The person responsible for implementing the plan of correction. The Administrator is responsible for implementing the correction action.	