STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 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 medical record review and staff interviews the facility failed to accurately assess 1 of 5 sampled residents utilizing the Minimum Data Set (MDS) in the area of pain management. (Resident #3) The findings included: Resident #3 was admitted to the facility 10/31/11 with diagnoses which included paraplegia, chronic pain and contracture. Review of physician orders for July 2018 for Resident #3 noted Resident #3 received a daily dose of Acetaminophen (pain medication). The specific order for Resident #3 read, 650 milligrams of Acetaminophen three times a day for pain. Review of the July 2018 Medication Administration Record for Resident #3 noted Acetaminophen was given every day. Review of the quarterly MDS dated 07/09/18 for Resident #3 noted under Section J/Pain Management that Resident #3 was assessed as not receiving scheduled pain medication in the past five days. Review of the care plan for Resident #3 noted a problem area of pain that was in place since 12/04/15 and read, Resident receives pain medication therapy related to chronic pain diagnoses and progression of disease progress.	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 641 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last 14 days to verify accurate coding of Section J of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #3 had a modification of section J to reflect accurate coding of receiving scheduled pain medication for Assessment Reference Date 7/9/18. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual.	9/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2018

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F 641	Continued From page 1 On 08/23/18 at 4:00 PM the MDS coordinator that assessed section J/Pain Management on the 07/09/18 quarterly MDS for Resident #3 stated the assessment of Resident #3's scheduled pain medication was coded in error and should have read yes. On 08/23/18 at 4:30 PM the Director of Nursing stated she expected the MDS to be an accurate reflection of the resident and would have expected Section J/Pain Management on the quarterly MDS dated 07/09/18 for Resident #3 to note yes to the question of a scheduled pain medication regimen.	F 641	2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in MDS coding of sections J related to accurate coding of MDS according to the RAI Manual on September 10, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for an additional 3 months to verify accurate coding of Section J of the MDS. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates	

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F 641	Continued From page 2	F 641	must be acceptable to the State. Date of Compliance: September 20, 2018	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		9/20/18

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F 656	Continued From page 3 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan for Activities of Daily Living (ADL) Functional/ Rehabilitation Potential for 1 of 6 residents (Resident #2) reviewed for ADL Functional/ Rehabilitation Potential. Findings included: Resident #2 was admitted to the facility on 7/30/2018. Resident #2 had diagnoses that included other non-traumatic intracerebral hemorrhage, essential hypertension, multiple myeloma not having achieved remission, left sided paresis with limited mobility and gout. Review of the Admission Minimum Data Set (MDS) dated 8/6/2018 revealed that Resident #2 was cognitively impaired. Resident #2 required extensive assistance with bed mobility, transfers, personal hygiene and toileting. Resident #2 required supervision with eating. The Care Area Assessment (CAA) summary sheet dated 8/10/2018 revealed ADL Functional/ Rehabilitation Potential triggered and the analysis	F 656	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 656 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a) The Resident Care Management Director (RCMD) or designee will complete an audit of all current residents care plans to ensure that Activities of Daily Living are addressed in the care plan and that appropriate interventions are implemented per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, revisions to the care plan will be completed by the RCMD and or MDS Designee per the RAI Manual guidelines. Resident #2 had a revision of their care plan to reflect their Activities of Daily Living status and that appropriate interventions are in place. The process breakdown occurred when the resident specific care plan did not correspond with the Resident Assessment Instrument	

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F 656	Continued From page 4 of findings indicated that there was an actual problem for Resident #2 completing her ADLs. The CAA worksheet further revealed that ADL Functional/ Rehabilitation Potential would be addressed in a plan of care for Resident #2. Review of the comprehensive plan of care dated 8/1/2018 and revised on 8/13/2018 contained no care plan for ADL Functional/ Rehabilitation Potential for Resident #2. An interview and observation with the MDS Nurse on 8/23/2018 at 3:57pm revealed that there was no care plan for ADL Functional/ Rehabilitation Potential for Resident #2. The MDS Nurse stated that the assessment would be completed and that would create the care area triggers. The care area triggers would prompt MDS or other disciplines to create their care plans. The MDS Nurse stated that an ADL care plan should have been developed. An interview with the Director of Nursing (DON) on 8/23/2018 at 4:12pm revealed that her expectation would be if a care area or CAA triggered, then there should be a care plan in place. An interview with the Administrator on 8/23/2018 at 4:19pm revealed that his expectation of staff would be that the information was captured in the plan of care.	F 656	Manual. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a) District Director Care Management will provide education to the Interdisciplinary Team members who participate in care plan implementation, according to the RAI Manual on September 10, 2018. The RCMD will randomly audit five care plans weekly for 12 weeks and then five random care plans monthly for an additional 3 months to verify all focus areas are addressed on the care plan. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a) The results of these audits will be presented by the Resident Care Management Director monthly for 6 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4. Title of person responsible for implementing the acceptable POC. a) The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5. Dates when corrective action will be completed. The corrective action dates	

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F 656	Continued From page 5	F 656	must be acceptable to the State. Date of Compliance: September 20, 2018	