

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

PRINTED: 05/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 04/16/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB/WAYNESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALL STREET WAYNESVILLE, NC 28786		
(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 431} SS=B	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	{F 431}		4/5/13	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 431}	<p>Continued From page 1</p> <p>2. Resident #3 was admitted to the facility on 01/18/13 with diagnoses which included dementia, bladder tumor and pain. The admission Minimum Data Set (MDS) assessment dated 01/25/13 assessed the resident as having short term memory problems and as having moderate impairment of cognitive skills for daily decision making. The MDS indicated Resident #3 did not receive scheduled pain medication but did receive pain medication as needed (PRN). Resident #3 was assessed as having frequent pain which was at a severity level of 8 on a scale of 0 to 10, with 10 indicating the most severe pain and 0 indicating no pain.</p> <p>A review of the physician's orders revealed an order dated 01/18/13 for Hydrocodone/acetaminophen 5/325 milligrams (mg) one every 4 hours PRN pain.</p> <p>A review of Resident #3 ' s April 2013 Medication Administration Record (MAR) and declining inventory record for the Hydrocodone/acetaminophen 5/325 mg revealed discrepancies in the documentation of administration of the medication. The discrepancies were as follows:</p> <p>A. Nurse #1 documented on 04/09/13 at 02:00 AM on the declining inventory record that she administered one Hydrocodone/acetaminophen 5/325 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>B. Nurse #2 documented on 04/10/13 at 12:30 PM on the declining inventory record that she administered one Hydrocodone/acetaminophen</p>	{F 431}			

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{F 431}	<p>Continued From page 2</p> <p>5/325 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>C. Medication Aide #1 documented on 04/14/13 at 08:00 PM on the declining inventory record that he administered one Hydrocodone/acetaminophen 5/325 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>D. Medication Aide #2 documented on 04/16/13 at 01:00 PM on the declining inventory record that he administered one Hydrocodone/acetaminophen 5/325 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>Nurse #1 and Nurse #2 were not available for interview during the survey.</p> <p>An interview was conducted on 04/16/13 at 4:01 PM with Medication Aide #2 about what he is expected to document regarding administration of PRN narcotic pain medication. He stated he is expected to initial the front of the MAR after giving the medication then on the back of the MAR he should document the date, time, medication, his initials and the reason for administering the medication. He said he is also expected to complete the PRN pain administration record. In addition, he stated he is expected to sign the medication out on the narcotic declining inventory record. Medication Aide #2 reviewed Resident #3's declining inventory record and April 2013 MAR. He stated he did give Resident #3 one Hydrocodone/acetaminophen 5/325 mg on</p>	{F 431}			

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{F 431}	<p>Continued From page 3</p> <p>04/16/13 at 01:00 PM as indicated on the declining inventory sheet but forgot to document it on the MAR. Medication Aide #2 stated he understood the importance of documenting administration of PRN medications on the MAR so the resident wouldn't get too much medication.</p> <p>An interview was conducted on 04/16/13 at 4:26 PM with Medication Aide # 1 about what he is expected to document regarding administration of PRN narcotic pain medication He stated he is expected to initial the front of the MAR after giving the medication then on the back of the MAR he should document the date, time, medication, his initials and the reason for administering the medication. He stated he is expected to chart the effectiveness of the medication an hour after he gives it. He said he is also expected to complete the PRN pain administration record. In addition, he stated he is expected to sign the medication out on the narcotic declining inventory record. Medication Aide #1 reviewed Resident #3's declining inventory record and April 2013 MAR. He stated he did give Resident #3 one Hydrocodone/acetaminophen 5/325 mg on 04/14/13 at 08:00 PM as indicated on the declining inventory sheet but forgot to document it on the MAR. Medication Aide #1 stated he understood the importance of documenting administration of PRN medications on the MAR so the medication wouldn't be given too soon.</p> <p>An interview on 04/16/13 at 04:35 PM with the Director of Nursing revealed she expected staff to document administration of all PRN medications by placing their initials on the front of the MAR; then to document the date, time, name, strength</p>	{F 431}			

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{F 431}	<p>Continued From page 4</p> <p>and dose of medication, reason for administration and effectiveness on the back of the MAR. The DON stated controlled substances should also be documented on the declining inventory record. The DON stated the documentation should match in all 3 places. The DON reviewed the April MAR and declining inventory record for Resident #3 and verified there were 4 discrepancies involving 2 nurses and 2 Medication Aides. The DON also confirmed the potential risk to the residents of getting too much PRN pain medication.</p> <p>Based on medical record reviews and staff interviews the facility failed to have matching documentation on the front and back of the Medication Administration Record (MAR) and the declining inventory record for the administration of narcotic as needed (PRN) pain medication for 2 of 3 sampled residents. (Residents #3 and 4). The findings included:</p> <p>1. Resident (#4) was admitted to the facility 04/20/12 with diagnoses which included open wounds and pressure ulcer. The most recent Minimum Data Set (MDS) dated 03/25/13, assessed the resident as being cognitively intact for daily decision making and as having no short term or long term memory problems. The MDS indicated Resident #4 received scheduled pain medication and PRN medication for pain. Resident #4 was assessed as having almost constant pain which was at a severity level of 10 on a scale of 0 to 10, with 10 indicating the most severe pain and 0 indicating no pain.</p> <p>A review of the April 2013 recapitulation of physician orders revealed Resident #4 had orders</p>	{F 431}			

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{F 431}	<p>Continued From page 5</p> <p>for oxycontin 80 milligrams (mg) extended release two tablets orally every 8 hours on a routinely scheduled basis and oxycodone 30 mg two tablets orally every 6 hours as needed (PRN). Both medications are used to treat pain.</p> <p>Review of Resident #4 's April 2013 Medication Administration Record (MAR) and declining inventory record for oxycodone 30 mg PRN for pain revealed discrepancies in the documentation of administration of the medication. The discrepancies were as follows:</p> <p>A. Medication Aide #2 documented on 04/08/13 at 01:00 PM on the declining inventory record that he administered 2 Oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>B. Nurse #4 documented on 04/12/13 at 02:30 PM on the declining inventory record that she administered 2 Oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>C. Nurse #3 documented on 04/14/13 at 02:30 AM on the declining inventory record that she administered 2 Oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>D. Nurse #3 documented on 04/14/13 at 05:00 PM on the declining inventory record that she administered 2 Oxycodone 30 mg. There was no documentation on the front or back of the MAR that the medication was administered.</p> <p>Nurse # 4 was not available for interview during</p>	{F 431}			

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{F 431}	<p>Continued From page 6 the survey.</p> <p>An interview with Medication Aide #2 on 04/16/13 at 04:01 PM revealed he was responsible for administering PRN medications on 04/08/13 for Resident #4. He stated that the expectation was to document administration of all PRN medications by placing his initials on the front of the MAR; then to document the date, time, and name, strength, and dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Medication Aide # 2 stated that controlled narcotics should also be documented on the declining inventory record and that the documentation should match in all three places. Medication Aide # 2 confirmed that he gave the medication as he had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/08/13 at 01:00 PM. Medication Aide # 2 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications.</p> <p>An interview with Nurse #3 on 04/16/13 04:11 PM revealed she was responsible for administering PRN medications on 04/14/13 for Resident #4. She stated that the expectation was to document administration of all PRN medications by placing her initials on the front of the MAR; then to document the date, time, and name, strength, dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. Nurse #3 stated that controlled narcotics should also be documented on the declining inventory record and that the documentation should match in all three places. Nurse #3 confirmed that she gave the</p>	{F 431}		

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{F 431}	<p>Continued From page 7</p> <p>medications as she had documented on the declining inventory record but missed documenting on the front and back of the MAR on 04/14/13 at 02:30 AM and 05:00 PM. Nurse #3 acknowledged that the importance of documenting appropriately ensures the safety of the resident to receive the correct medications.</p> <p>An interview with the Director of Nursing (DON) on 04/16/13 at 04:35 PM revealed she expected staff to document administration of all PRN medications by placing their initials on the front of the MAR; then to document the date, time, name, strength, dose of medication, reason for administration and the effectiveness of the medication on the back of the MAR. The DON stated controlled narcotics should also be documented on the declining inventory record. The DON confirmed that the documentation should match in all three places. The DON reviewed the April MAR and declining inventory record for Resident #4 and verified there were 4 discrepancies involving 2 nurses and 1 Medication Aide. The DON confirmed the documentation discrepancies and the potential risk to the residents of getting too much PRN pain medication.</p>	{F 431}		