

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

PRINTED: 12/15/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345323</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CTR HLTH &amp; REHABILITATIO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>647 S RAILROAD STREET BOX 966 WALLACE, NC 28466</b>	
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F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to obtain clarification regarding 1 of 1 sampled residents (Resident #16) with a bubble pack of Plavix (medication used to prevent blood clots) on the medication cart but without an order to administer it in the electronic medication administration system which was needed to guarantee the resident was receiving Plavix daily as ordered by the physician. Findings included: Record review revealed Resident #16 was admitted to the facility on 10/23/13 with a physician order for Plavix (anti-platelet medication) 75 milligrams (mg) daily. The resident's documented diagnoses included cerebrovascular accident with left hemiparesis. Review of Resident #16's electronic medication administration record (e-MAR), by which the nursing staff began administering medications on 10/01/16, revealed the physician order for Plavix had not been transcribed from the paper system into the electronic system. An observation on 11/10/16 at 10:06 AM revealed that resident #16 had a bubble pack of Plavix 75mg in the medication cart with six missing. The bubble pack was received from the pharmacy on 10/28/16. In an interview conducted on 11/10/2016 at 10:40 AM Nurse #2 was unable to locate an order for Plavix on the e-MAR. However, she stated that she administered the Plavix 75 mg to Resident</p>	F 281	<p>Resident #16's attending physician was notified and clarification order written regarding Plavix on 11/10/16 by Regina Smith.</p> <p>The Director of Nursing and other clinical managers will complete audit of facility resident medication to ensure that physician ordered for past ninety days had been entered into electronic medical record or discontinue per physician orders on 11/9/16- 11/11/16.</p> <p>The facility licensed staff will be provided re-education regarding accurately transcribing physician orders/ entering orders into electronic medical record and five rights regarding medication administration on 11/10/16 by Diane Smith. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired licensed nurses that do not receive the re-education by 11/10/16 will receive it prior to working next shift.</p> <p>The Director of Nursing or designee will review the physician orders for previous day to ensure that medications have been transcribed and are being given per physician orders for thirty days and</p>	12/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/08/2016

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	<p>Continued From page 1</p> <p>#16 this morning anyway because the resident had been on Plavix "forever." She revealed that she gave the medication without looking at the e-MAR. She was not sure if other nurses who worked on the cart were giving the Plavix or not.</p> <p>In an interview conducted on 11/10/16 at 11:10 AM with Nurse #3 she confirmed that she only passed medications listed on the e-MAR. She said if there was a medication bubble pack in a resident 's drawer that was not listed on the e-MAR she would investigate why the medication was in the drawer and either send it back to the pharmacy or give it to the resident depending upon the results of her investigation. She commented that such an investigation had not been conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:11 AM with Nurse #4 she stated that she would not give a medication unless it was listed on the e-MAR. She revealed that she flagged medications found in the medication cart without corresponding orders in the e-MAR until she could investigate if the medication was to be given. However, she commented she was unaware of such an investigation being conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:15 AM with Nurse #5 she revealed that she passed medications listed in the e-MAR. She stated she would not give a medication if it was not listed on the computer. She would investigate the medication and return it to the pharmacy if it was discontinued. However, she commented she was unaware of such an investigation being conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:28 AM with the facility's corporate pharmacist she revealed that there was an active order for</p>	F 281	<p>monthly times two.</p> <p>The Director of Nursing will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 281	<p>Continued From page 2</p> <p>Resident #16 to receive Plavix 75 mg daily that had been in effect for the last three years. She stated the pharmacy was not responsible for the e-MAR. She reported the facility was responsible for keying information into the e-MAR.</p> <p>In an interview conducted on 11/10/16 at 11:45 AM with the Director of Nursing she said the nurses were to only pass those medications listed in the e-MAR. She revealed that the facility had been having trouble auditing the transition from paper charting to the e-MAR. She commented she was unsure how the Plavix order for Resident #16 was missed during the transition of orders from paper to the electronic system. She stated she would not expect a nurse to give a medication that was not listed on the e-MAR. She would expect the nurse to pull the medication and investigate why it was not listed on the computer e-MAR. She would then expect the nurse to call the doctor to reinstate the order if it had not been discontinued or to send the medication back to the pharmacy if it was discontinued. She reported the nursing staff should have sought clarification when they discovered Resident #16 had Plavix on the medication cart but was without an order to administer it in the electronic system. She confirmed that it could not be determined whether Resident #16 received Plavix daily since the 10/01/16 transition between paper MARs and e-MARs because since 10/01/16 there was no place to document any administration.</p> <p>At 12:10 PM on 11/15/16, during a telephone interview, the medical director and primary physician for Resident #16 stated Plavix was more effective when it was administered at about the same time daily, and the side effects of not receiving it daily varied depending on the</p>	F 281			

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F 281	Continued From page 3 progression of the resident's heart disease and whether the resident was receiving other anti-platelet medications. Again, she reported going without the Plavix or having erratic doses for a couple of weeks would be less likely to cause problems than going without it or having erratic dosing for longer periods of time.	F 281			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356		12/9/16	

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F 356	<p>Continued From page 4 required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post nursing staffing for 2 consecutive days of the survey.</p> <p>Findings included:</p> <p>At 10:06 AM on 11/07/16, an observation revealed the Posted Staffing was dated 11/05/16. There were no Posted Staffing sheets observed for 11/06/16 or 11/07/16.</p> <p>In an interview with the Director of Nursing (DON) at 2:33 PM on 11/9/16, she stated that staff posting was usually done between 8:00 AM and 8:30 AM each day. She reported that for weekend posting, she would print out the sheets on Fridays and the nursing staff would update the census and staffing information for each shift, as needed, before posting the staffing. The DON stated that her expectation was that staffing be posted each day between 8:00 AM and 8:30 AM and that the information for each shift be accurate.</p> <p>In an interview with the Administrator at 5:40 PM on 11/09/16, he stated that his expectation was that the staffing would be accurate and posted daily.</p>	F 356	<p>Staffing was posted on 11/8/16.</p> <p>The scheduler/designee will post the staffing sheet at the nurse's station daily Monday through Friday at the beginning of the 7-3 shift. Weekend staffing sheets will be made in advance and placed on the clip board. Licensed staff will be educated on the process of changing out the daily staffing sheets by and making any adjustments at the beginning of the 7-3 shift on the weekends. Educated by Lisa Sumner 12/8/16.</p> <p>Department managers will be educated regarding the changes to their duties regarding staff posting documentation by Administrator and completed on 12/8/16. Newly Hired department managers will receive the education during orientation. The facilities department managers that do not receive the education by 12/8/16 will receive it prior to working next shift.</p> <p>The Manager on Duty will validate that the staffing is posted and document on the Manager on Duty checklist. Negative findings will be corrected if noted.</p> <p>Daily monitoring of the staffing sheets will be conducted by the administrator, director of nursing or assistant director of nursing. The sheets will be reviewed weekly for 4 weeks and monthly times 2</p>		

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F 356	Continued From page 5	F 356	months.		
F 428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on consultant pharmacy interview, staff interview, and record review consultant pharmacists failed to alert the facility to problems with medication issues in the electronic medication administration (e-MAR system) for 3 of 6 residents (Resident #16, #50, and #129) whose medications were reviewed. The pharmacists failed to alert the facility that while Resident #16 had a punch card for Plavix medication there was no order in the e-MAR system for the medication. The pharmacists</p>	F 428	<p>The results of all staffing sheets will be reviewed monthly for three months by the Quality Assurance Performance Improvement committee. The committee will monitor for negative patterns/trends and determine if additional interventions are necessary to maintain substantial compliance.</p> <p>Resident #16's attending physician was notified and clarification order written regarding Plavix on 11/10/16 by Regina Smith.</p> <p>Resident #50's attending physician notified on 11/10/16 and clarification order was written regarding magnesium oxide by the director of nursing.</p> <p>Resident #129's attending physician was</p>	12/9/16	

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F 428	<p>Continued From page 6</p> <p>failed to alert the facility that magnesium supplementation was resumed for Resident #50 without a physician order to do so. The pharmacist failed to alert the facility that medications were not being initialed as being given electronically for Resident #129. Findings included:</p> <p>1. Record review revealed Resident #16 was admitted to the facility on 10/23/13 with a physician order for Plavix (anti-platelet medication) 75 milligrams (mg) daily. The resident's documented diagnoses included cerebrovascular accident with left hemiparesis. Review of Resident #16's electronic medication administration record (e-MAR), by which the nursing staff began administering medications on 10/01/16, revealed the physician order for Plavix had not been transcribed from the paper system into the electronic system.</p> <p>An observation on 11/10/16 at 10:06 AM revealed that resident #16 had a bubble pack of Plavix 75mg in the medication cart with six missing. The bubble pack was received from the pharmacy on 10/28/16.</p> <p>In an interview conducted on 11/10/2016 at 10:40 AM Nurse #2 was unable to locate an order for Plavix on the e-MAR. However, she stated that she administered the Plavix 75 mg to Resident #16 this morning anyway because the resident had been on Plavix "forever." She revealed that she gave the medication without looking at the e-MAR. She was not sure if other nurses who worked on the cart were giving the Plavix or not.</p> <p>In an interview conducted on 11/10/16 at 11:10 AM with Nurse #3 she confirmed that she only passed medications listed on the e-MAR. She said if there was a medication bubble pack in a</p>	F 428	<p>notified regarding incomplete documentation regarding administration of calcium carbonate, cosport solution, ambien, and flovent aerosol on 11/10/16.</p> <p>The Director of Nursing and clinical managers completed audit of facility resident medication record to ensure that medication had been initialed as given for the month of November. Attending physician was notified of resident identified with incomplete documentation regarding administration of prescribed medication on 11/10/16 by clinical managers.</p> <p>Daily medication record will be monitored by DON or designee to ensure that physician orders are transcribed accurately and will check for missing documentation on the medication administration record to ensure that medications are given per physician orders.</p> <p>The facility's licensed nurses were provided re-education regarding documentation of medication administration by Diane Smith on 11/9/16 and completed. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired nurses that do not receive the education by 11/9/16 will receive it prior to working next shift.</p> <p>Director of nursing and administrator educated pharmacy consultant on expectations of monthly visits to include</p>		

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F 428	Continued From page 7 resident ' s drawer that was not listed on the e-MAR she would investigate why the medication was in the drawer and either send it back to the pharmacy or give it to the resident depending upon the results of her investigation. She commented that such an investigation had not been conducted for Resident #16. In an interview conducted on 11/10/16 at 11:11 AM with Nurse #4 she stated that she would not give a medication unless it was listed on the e-MAR. She revealed that she flagged medications found in the medication cart without corresponding orders in the e-MAR until she could investigate if the medication was to be given. However, she commented she was unaware of such an investigation being conducted for Resident #16. In an interview conducted on 11/10/16 at 11:15 AM with Nurse #5 she revealed that she passed medications listed in the e-MAR. She stated she would not give a medication if it was not listed on the computer. She would investigate the medication and return it to the pharmacy if it was discontinued. However, she commented she was unaware of such an investigation being conducted for Resident #16. At 1:12 PM on 11/10/16, during a telephone conversation, Consultant Pharmacist #1 stated during her monthly medication reviews she reviewed orders and medication administration documented in the electronic record keeping system. During her October 2016 reviews she reported she noticed there were orders entered incorrectly in the electronic system, there were orders omitted from the electronic system, and there were holes in the administration records where staff were not initialing off that they provided medications. However, when she reviewed her October 2016 pharmacy	F 428	auditing medication records for missing documentation, physician orders checking for transcription errors, and duplication of orders on 12/9/16.  The Director of nursing will report findings of daily monitoring and pharmacy consultant reports to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.		



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F 428	<p>Continued From page 8</p> <p>recommendations for Resident #16 she reported she did not catch that the resident ' s order for Plavix was not carried over from the paper administration system into the electronic system on 10/01/16.</p> <p>At 1:28 PM on 11/10/16, during a telephone conversation, Consultant Pharmacist #2 stated during his monthly medication reviews he reviewed orders and medication administration documented in the electronic record keeping system. During his 11/02/16 and 11/03/16 medication reviews he reported he did not catch that resident #16 ' s order for Plavix was not carried over from the paper administration system into the electronic system on 10/01/16. He commented he did not discuss order accuracy and missing documentation with the facility since he understood the facility ' s usual pharmacist (Consultant Pharmacist #1) had discussed these issues with the facility the month before.</p> <p>2. Record review revealed Resident #50 was admitted to the facility on 06/04/16. The resident's documented diagnoses included atherosclerotic heart disease, history of myocardial infarction, hypertension, and dementia.</p> <p>A 07/21/16 physician order specified magnesium oxide 400 milligrams (mg) twice daily (BID) at 8:00 AM and 8:00 PM was to be discontinued, and the resident was to be started on magnesium oxide 400 mg daily (QD) at 9:00 AM. A magnesium level was to be determined for the resident in two weeks via a lab draw.</p> <p>Lab results received on 08/04/16 documented Resident #50's magnesium level was 2.3</p>	F 428			

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F 428	<p>Continued From page 9</p> <p>milligrams per deciliter (mg/dL) with the normal range being 1.6 - 2.3 mg/dL.</p> <p>A 08/04/16 physician order documented Resident #50's magnesium oxide was to be discontinued.</p> <p>Review of Resident #50's August 2016 and September 2016 paper medication administration records (MARs) revealed the resident did not receive any magnesium oxide from 08/05/16 through 09/30/16.</p> <p>Resident #50's 09/22/16 quarterly minimum data set (MDS) documented his cognition was severely impaired, he exhibited no behaviors including rejection of care, and he required extensive assistance from staff to being totally dependent on staff for all his activities of daily living (ADLs) except eating.</p> <p>Review of the facility's electronic medication administration record (e-MAR) revealed there was documentation in the system that on 09/29/16 orders for both magnesium oxide BID and QD were "revised."</p> <p>On 10/01/16, when the facility transitioned between paper MARs and the e-MAR system, orders for both magnesium oxide BID and QD appeared on the e-MAR for Resident #50.</p> <p>Record review revealed there were no physician orders, physician progress notes, or nursing notes that documented Resident #50's magnesium supplementation should have been resumed.</p> <p>Review of Resident #50's October 2016 e-MAR documented he received 24 doses of magnesium</p>	F 428			

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F 428	<p>Continued From page 10</p> <p>oxide 400 mg at 8:00 AM, 21 doses of magnesium oxide 400 mg at 9:00 AM, and 23 doses of magnesium oxide 400 mg at 8:00 PM from 10/01/16 through 10/31/16.</p> <p>Review of Resident #50's November 2016 e-MAR documented he received 9 doses of magnesium oxide 400 mg at 8:00 AM, and 8 doses of magnesium oxide 400 mg at 9:00 AM from 11/01/16 through 11/09/16.</p> <p>11/10/16 lab results documented Resident #50's magnesium level was 2.3 mg/dL with the normal range being 1.6 - 2.3 mg/dL.</p> <p>At 1:12 PM on 11/10/16, during a telephone conversation, Consultant Pharmacist #1 stated during her monthly medication reviews she reviewed orders and medication administration documented in the electronic record keeping system. During her October 2016 reviews she reported she noticed there were orders entered incorrectly in the electronic system, there were orders omitted from the electronic system, and there were holes in the administration records where staff were not initialing off that they provided medications. However, when she reviewed her October 2016 pharmacy recommendations for Resident #50 she reported she did not catch that the resident's order for magnesium oxide (which was discontinued on 08/04/16) was somehow introduced back into the electronic system without a physician order to do so when the facility transitioned from the paper medication administration system to the electronic system on 10/01/16.</p> <p>At 1:28 PM on 11/10/16, during a telephone conversation, Consultant Pharmacist #2 stated</p>	F 428			

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F 428	<p>Continued From page 11</p> <p>during his monthly medication reviews he reviewed orders and medication administration documented in the electronic record keeping system. During his 11/02/16 and 11/03/16 medication reviews he reported he did not catch that Resident #50's discontinued order for magnesium oxide was reactivated without a physician order to do so when the facility transitioned from the paper medication administration system to the electronic system on 10/01/16. He commented he did not discuss order accuracy and missing documentation with the facility since he understood the facility's usual pharmacist (Consultant Pharmacist #1) had discussed these issues with the facility the month before.</p> <p>3. Resident #129 was admitted to the facility on 10/28/16 with a diagnosis history that included acute cholecystitis, chronic atrial fibrillation, diabetes mellitus, atherosclerotic heart disease of native coronary artery, stage 3 chronic kidney disease, and hypothyroidism.</p> <p>A review of physician orders, dated 10/28/16, showed that Resident # 129 was ordered the following medications:</p> <ol style="list-style-type: none"> <li>1. Calcium Carbonate - Vit D - Min Tablet 600-200 Mg-Unit: Give 1 tablet by mouth at bedtime for supplement.</li> <li>2. Cosopt Solution 22.3-6.8 mg/ml: Instill 1 drop in left eye two times a day for glaucoma.</li> <li>3. Ambien Tablet 5 mg: Give 1 tablet by mouth at bedtime for insomnia.</li> <li>4. Flovent HFA Aerosol 110 Mcg/act: 2 puff inhale orally two times a day for SOB/wheezing.</li> </ol> <p>A review of the electronic medication</p>	F 428			

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F 428	Continued From page 12 administration record (e-MAR) for Resident #129 revealed that the resident's calcium carbonate-vitamin D tablet, Cosopt solution, Ambien, and Flovent were not initialed off as given at bedtime (9:00 PM) on 10/31, 11/01, 11/02, 11/03, 11/04, 11/05, 11/06, and 11/08/16.  At 11:18 AM on 11/10/16 Nurse #1 stated she did administer PM doses of Flovent, Cosopt, Ambien, and calcium/vitamin D to Resident #129, but could not figure out how to document this administration in the e-MAR.  At 1:28 PM on 11/10/16, during a telephone conversation, Consultant Pharmacist #2 stated during his monthly medication reviews he reviewed orders and medication administration documented in the electronic record keeping system. During his 11/02/16 and 11/03/16 medication reviews he reported he did not catch that Resident #129's PM administration of medications was not be initialed off on the e-MAR as given. He commented he did not discuss order accuracy and missing documentation with the facility since he understood the facility's usual pharmacist (Consultant Pharmacist #1) had discussed these issues with the facility the month before.	F 428			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441		12/9/16	

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F 441	<p>Continued From page 13</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to post an isolation sign outside a resident's door for 1 of 1 resident who was placed on isolation precautions (Resident #56). Findings included: Review of the Physician Telephone Orders dated</p>	F 441	<p>Resident #56 no longer requires isolation</p> <p>Facility resident identified with infection requiring isolation were reviewed to ensure appropriate signage were in place on 11/8/16 by Lisa Sumner.</p>		

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F 441	Continued From page 14 10/28/16 showed Resident #56 was on Contact Isolation Precautions for methicillin-resistant staphylococcus aureus (MRSA) on her chin. An observation on 11/07/16 at 10:30 AM and 11/8/16 5 at 8:30 AM revealed a Personal Protection Equipment (PPE) box hanging on the outside of Resident #56's door. No Contact Isolation sign was observed on the resident's door or in the resident's room. In an interview on 11/08/16 at 8:41 AM Nurse #2 stated there should have been a Contact Isolation precaution sign posted on Resident #56's door starting of 10/28/16, and there was not. In an interview on 11/08/16 at 8:45 AM with the Director of Nursing (DON) she stated that it was her expectation that a Contact Isolation sign should have been posted on Resident #56's door by the nurse assigned to Resident #56's hall starting on 10/28/16, and it was not. In an interview on 11/08/16 at 9:12 AM Nurse #3 stated Resident #56 was the only resident in the facility on Contact Isolation precautions, and that was for MRSA on her chin.	F 441	The Director of Nursing will observe resident identified with infections requiring isolation to ensure appropriate signage posted times thirty days.  The facility licensed nurses will be provided re-education regarding required signage for residents identified with an infection requiring isolation on 11/8/16 and completed by Lisa Sumner. Newly hired licensed nurses will receive the education during orientation. The facilities newly hired licensed nurses that do not receive the re-education by 11/8/16 will receive it prior to working next shift.  The director of nursing will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility's administration failed to	F 490	Resident #16's attending physician was notified and clarification order written	12/9/16

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F 490	<p>Continued From page 15</p> <p>prepare staff for and implement the conversion from paper medication administration records (MARs) to electronic medication administration records (e-MARs) which resulted in physician orders for 1 of 1 sampled residents (Resident #16) on Plavix (anti-platelet medication) not getting transcribed into the e-MAR system, in restarting magnesium supplementation without a physician's order for 1 of 5 residents (Resident #50) reviewed for unnecessary medications, and in nurses being unable to accurately document the administration of medications for 1 of 5 residents (Resident #129) reviewed for unnecessary medications. Findings included:</p> <p>This tag is cross-referenced to:</p> <p>F281: Based on observation, staff interview, and record review the facility failed to obtain clarification regarding 1 of 1 sampled residents (Resident #16) with a bubble pack of Plavix (medication used to prevent blood clots) on the medication cart but without an order to administer it in the electronic medication administration system which was needed to guarantee the resident was receiving Plavix daily as ordered by the physician.</p> <p>F329: Unnecessary Medications: Based on physician interview, staff interview, and record review the facility failed to discontinue the administration of magnesium as ordered by the physician for 1 of 5 sampled residents (Resident #50) who was reviewed for unnecessary medications.</p> <p>F514: Complete and Accurate Medical Records: Based on staff interview and record review the facility failed to accurately audit orders</p>	F 490	<p>regarding Plavix on 11/10/16 by Regina Smith.</p> <p>The Director of Nursing and other clinical managers will complete audit of facility resident medication to ensure that physician ordered for past ninety days had been entered into electronic medical record or discontinue per physician orders on 11/9/16- 11/10/16.</p> <p>The facility licensed staff will be provided re-education regarding accurately transcribing physician orders/ entering orders into electronic medical record and five rights regarding medication administration on 11/10/16 by Diane Smith. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired licensed nurses that do not receive the re-education by 11/10/16 will receive it prior to working next shift.</p> <p>The Director of Nursing or designee will review the physician orders for previous day to ensure that medications have been transcribed and are being given per physician orders for thirty days and monthly times two.</p> <p>The Director of nursing or designee will review medication administration record daily for missing documentation to ensure that medication is being given per physician orders.</p> <p>The Director of Nursing will report findings of outcome of monitoring to the facility</p>		



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F 490	<p>Continued From page 16</p> <p>transcribed from a paper medication administration record (MAR) into the electronic medication administration record (e-MAR), and failed to audit the e-MAR after the transition to make sure nurses were documenting medication administration correctly. This resulted in incomplete and inaccurate medical records for 1 of 1 sampled resident (Resident #16) whose order for Plavix was not carried forward from the paper MAR to the e-MAR, for 1 of 5 sampled residents reviewed for unnecessary medications whose e-MAR documented he received magnesium oxide until 11/10/16 when it was supposed to be discontinued as of 08/04/16, and for 1 of 5 sampled residents (Resident #129) reviewed for unnecessary medications who was not having the administration of his PM doses of Ambien, Flovent, Cosopt, and calcium/vitamin D documented on the e-MAR.</p> <p>At 12:20 PM on 11/10/16 the director of nursing (DON) stated since the first or second week in October 2016 there were problems with in-putting orders, documenting the administration of medications, glitches in the e-MAR system, and transcribing orders from the paper system to the electronic system. She explained the e-MAR system "went live" on 10/01/16. The DON reported two nurses came to her in the past week and a half with concerns about documenting the administration of their medications correctly. She commented she attempted to provide 1:1 education to these two nurses, but was not sure it was effective.</p> <p>At 12:10 PM on 11/15/16, during a telephone interview, the medical director stated the facility held a few training sessions before use of the e-MAR system began on 10/01/16. However,</p>	F 490	<p>Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Resident #129's attending physician was notified regarding incomplete documentation regarding administration of calcium carbonate, cosport solution, ambien, and flovent aerosol on 11/10/16.</p> <p>The Director of Nursing and clinical managers completed audit of facility resident medication record to ensure that medication had been initialed as given for the month of November. Attending physician was notified of resident identified with incomplete documentation regarding administration of prescribed medication on 11/10/16 by clinical managers.</p> <p>The facility's licensed nurses were provided re-education regarding documentation of medication administration by Diane Smith on 11/9/16. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired nurses that do not receive the education by 11/9/16 will receive it prior to working next shift.</p> <p>Resident #50's attending physician notified on 11/9/16 and clarification order was written regarding magnesium oxide by the director of nursing.</p>		

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F 490	Continued From page 17 she reported she felt this training was inadequate, and the staff were not well prepared for the transition between paper MARs and the e-MAR system because there were daily problems with transcription of orders and documentation of medication administration. According to the medical director, she still felt there were problems in the e-MAR system which had yet to be worked out.	F 490	<p>The director of nursing and other clinical managers will complete audit of facility resident medication to ensure that physician ordered for past ninety days had been entered into electronic medical record or discontinue per physician orders on 11/9/16-11/10/16.</p> <p>The facility licensed staff will be provided re-education regarding accurately transcribing physician orders and entering orders into electronic medical record on 11/10/16 by Lisa Sumner. Newly hired licensed nurses will receive the education during orientation. The facility's licensed nurses that do not receive the re-education by 11/10/16 will receive it prior to working next shift.</p> <p>The Director of Nursing or designee will review the physician orders for previous day to ensure that medication have been transcribed and being given per physician orders for thirty days and bi monthly times two and monthly times one.</p> <p>The Director of nursing or designee will review medication administration record daily for missing documentation to ensure that medication is being given per physician orders.</p> <p>The Director of Nursing will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The</p>		

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F 490	Continued From page 18	F 490			
F 514 SS=E	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to accurately audit orders transcribed from a paper medication administration record (MAR) into the electronic medication administration record (e-MAR), and failed to audit the e-MAR after the transition to make sure nurses were documenting medication administration correctly. This resulted in incomplete and inaccurate medical records for 1 of 1 sampled resident (Resident #16) whose order for Plavix was not carried forward from the paper MAR to the e-MAR, for 1 of 5 sampled residents reviewed for unnecessary medications whose e-MAR documented he received magnesium oxide until 11/10/16 when it was</p>	F 514	<p>committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Resident #16's attending physician was notified and clarification order written regarding Plavix on 11/10/16 by Regina Smith.</p> <p>The Director of Nursing and other clinical managers will complete audit of facility resident medication to ensure that physician ordered for past ninety days had been entered into electronic medical record or discontinue per physician orders on 11/9/16- 11/10/16.</p> <p>The facility licensed staff will be provided re-education regarding accurately</p>	12/9/16	

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F 514	<p>Continued From page 19</p> <p>supposed to be discontinued as of 08/04/16, and for 1 of 5 sampled residents (Resident #129) reviewed for unnecessary medications who was not having the administration of his PM doses of Ambien, Flovent, Cosopt, and calcium/vitamin D documented on the e-MAR. Findings included:</p> <p>1. Record review revealed Resident #16 was admitted to the facility on 10/23/13 with a physician order for Plavix (anti-platelet medication) 75 milligrams (mg) daily. The resident's documented diagnoses included cerebrovascular accident with left hemiparesis. Review of Resident #16's electronic medication administration record (e-MAR), by which the nursing staff began administering medications on 10/01/16, revealed the physician order for Plavix had not been transcribed from the paper system into the electronic system.</p> <p>An observation on 11/10/16 at 10:06 AM revealed that resident #16 had a bubble pack of Plavix 75mg in the medication cart with six missing. The bubble pack was received from the pharmacy on 10/28/16.</p> <p>In an interview conducted on 11/10/2016 at 10:40 AM Nurse #2 was unable to locate an order for Plavix on the e-MAR. However, she stated that she administered the Plavix 75 mg to Resident #16 this morning anyway because the resident had been on Plavix "forever." She revealed that she gave the medication without looking at the e-MAR. She was not sure if other nurses who worked on the cart were giving the Plavix or not.</p> <p>In an interview conducted on 11/10/16 at 11:10 AM with Nurse #3 she confirmed that she only passed medications listed on the e-MAR. She said if there was a medication bubble pack in a resident 's drawer that was not listed on the e-MAR she would investigate why the medication</p>	F 514	<p>transcribing physician orders/ entering orders into electronic medical record and five rights regarding medication administration on 11/10/16 by Diane Smith. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired licensed nurses that do not receive the re-education by 11/10/16 will receive it prior to working next shift.</p> <p>The Director of Nursing or designee will review the physician orders for previous day to ensure that medications have been transcribed and are being given per physician orders for thirty days and monthly times two.</p> <p>The Director of Nursing will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p> <p>Resident #129's attending physician was notified regarding incomplete documentation regarding administration of calcium carbonate, cosport solution, ambien, and flovent aerosol on 11/10/16.</p> <p>The Director of Nursing and clinical managers completed audit of facility resident medication record to ensure that medication had been initialed as given for the month of November. Attending physician was notified of resident</p>		

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F 514	<p>Continued From page 20</p> <p>was in the drawer and either send it back to the pharmacy or give it to the resident depending upon the results of her investigation. She commented that such an investigation had not been conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:11 AM with Nurse #4 she stated that she would not give a medication unless it was listed on the e-MAR. She revealed that she flagged medications found in the medication cart without corresponding orders in the e-MAR until she could investigate if the medication was to be given. However, she commented she was unaware of such an investigation being conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:15 AM with Nurse #5 she revealed that she passed medications listed in the e-MAR. She stated she would not give a medication if it was not listed on the computer. She would investigate the medication and return it to the pharmacy if it was discontinued. However, she commented she was unaware of such an investigation being conducted for Resident #16.</p> <p>In an interview conducted on 11/10/16 at 11:28 AM with the facility's corporate pharmacist he revealed that there was an active order for Resident #16 to receive Plavix 75 mg daily that had been in effect for the last three years. He stated the pharmacy was not responsible for the e-MAR. He reported the facility was responsible for keying information into the e-MAR.</p> <p>In an interview conducted on 11/10/16 at 11:02 AM with the Director of Nursing she stated Resident #16's medical record was not accurate and complete because some nurses were administering Plavix to the resident without an order in the e-MAR, and its administration was not being captured.</p>	F 514	<p>identified with incomplete documentation regarding administration of prescribed medication on 11/10/16 by clinical managers.</p> <p>The facility's licensed nurses were provided re-education regarding documentation of medication administration by Diane Smith on 11/9/16. Newly hired licensed nurses will receive the education during orientation. The facility's newly hired nurses that do not receive the education by 11/9/16 will receive it prior to working next shift.</p> <p>Resident #50's attending physician notified on 11/9/16 and clarification order was written regarding magnesium oxide by the director of nursing.</p> <p>The director of nursing and other clinical managers will complete audit of facility resident medication to ensure that physician ordered for past ninety days had been entered into electronic medical record or discontinue per physician orders on 11/9/16-11/10/16.</p> <p>The facility licensed staff will be provided re-education regarding accurately transcribing physician orders and entering orders into electronic medical record on 11/10/16 by Lisa Sumner. Newly hired licensed nurses will receive the education during orientation. The facility's licensed nurses that do not receive the re-education by 11/10/16 will receive it prior to working next shift.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CTR HLTH &amp; REHABILITATIO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>647 S RAILROAD STREET BOX 966 WALLACE, NC 28466</b>		
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F 514	<p>Continued From page 21</p> <p>2. Record review revealed Resident #50 was admitted to the facility on 06/04/16. The resident's documented diagnoses included atherosclerotic heart disease, history of myocardial infarction, hypertension, and dementia.</p> <p>A 07/21/16 physician order specified magnesium oxide 400 milligrams (mg) twice daily (BID) at 8:00 AM and 8:00 PM was to be discontinued, and the resident was to be started on magnesium oxide 400 mg daily (QD) at 9:00 AM. A magnesium level was to be determined for the resident in two weeks via a lab draw.</p> <p>Lab results received on 08/04/16 documented Resident #50's magnesium level was 2.3 milligrams per deciliter (mg/dL) with the normal range being 1.6 - 2.3 mg/dL.</p> <p>A 08/04/16 physician order documented Resident #50's magnesium oxide was to be discontinued.</p> <p>Review of Resident #50's August 2016 and September 2016 paper medication administration records (MARs) revealed the resident did not receive any magnesium oxide from 08/05/16 through 09/30/16.</p> <p>Resident #50's 09/22/16 quarterly minimum data set (MDS) documented his cognition was severely impaired, he exhibited no behaviors including rejection of care, and he required extensive assistance from staff to being totally dependent on staff for all his activities of daily living (ADLs) except eating.</p> <p>Review of the facility's electronic medication administration record (e-MAR) revealed there</p>	F 514	<p>The Director of Nursing or designee will review the physician orders for previous day to ensure that medication have been transcribed and being given per physician orders for thirty days and bi monthly times two and monthly times one.</p> <p>The Director of nursing or designee will review medication administration record daily for missing documentation to ensure that medication is being given per physician orders.</p> <p>The Director of Nursing will report findings of outcome of monitoring to the facility Quality Assurance and Performance Improvement committee weekly times four and monthly times two. The committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.</p>		

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F 514	<p>Continued From page 22</p> <p>was documentation in the system that on 09/29/16 orders for both magnesium oxide BID and QD were "revised."</p> <p>On 10/01/16, when the facility transitioned between paper MARs and the e-MAR system, orders for both magnesium oxide BID and QD appeared on the e-MAR for Resident #50.</p> <p>Record review revealed there were no physician orders, physician progress notes, or nursing notes that documented Resident #50's magnesium supplementation should have been resumed.</p> <p>Review of Resident #50's October 2016 e-MAR documented he received 24 doses of magnesium oxide 400 mg at 8:00 AM, 21 doses of magnesium oxide 400 mg at 9:00 AM, and 23 doses of magnesium oxide 400 mg at 8:00 PM from 10/01/16 through 10/31/16.</p> <p>Review of Resident #50's November 2016 e-MAR documented he received 9 doses of magnesium oxide 400 mg at 8:00 AM, and 8 doses of magnesium oxide 400 mg at 9:00 AM from 11/01/16 through 11/09/16.</p> <p>11/10/16 lab results documented Resident #50's magnesium level was 2.3 mg/dL with the normal range being 1.6 - 2.3 mg/dL.</p> <p>In an interview conducted on 11/10/16 at 11:02 AM with the Director of Nursing she stated Resident #50's medical record was not accurate because Resident #50 was not supposed to be receiving magnesium oxide after 08/04/16, but received it until 11/10/16 according to the e-MAR.</p> <p>3. Resident #129 was admitted to the facility on 10/28/16 with a diagnosis history that included</p>	F 514			

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F 514	<p>Continued From page 23</p> <p>acute cholecystitis, chronic atrial fibrillation, diabetes mellitus, atherosclerotic heart disease of native coronary artery, stage 3 chronic kidney disease, and hypothyroidism.</p> <p>Minimum Data Set (MDS) information for Resident # 129 was not yet available due to his recent admission, but a Brief Interview for Mental Status (BIMS) assessment, completed on 10/28/16 indicated that his cognition was intact.</p> <p>A review of physician orders, dated 10/28/16, showed that Resident #129 was ordered the following medications:</p> <ol style="list-style-type: none"> <li>1. Calcium Carbonate - Vit D - Min Tablet 600-200 Mg-Unit: Give 1 tablet by mouth at bedtime for supplement.</li> <li>2. Cosopt Solution 22.3-6.8 mg/ml: Instill 1 drop in left eye two times a day for glaucoma.</li> <li>3. Ambien Tablet 5 mg: Give 1 tablet by mouth at bedtime for insomnia.</li> <li>4. Flovent HFA Aerosol 110 Mcg/act: 2 puff inhale orally two times a day for SOB/wheezing.</li> </ol> <p>A review of the electronic medication administration record (e-MAR) for Resident #129 revealed that the resident's calcium carbonate-vitamin D tablet, Cosopt solution, Ambien, and Flovent were not initialed off as given at bedtime (9:00 PM) on 10/31, 11/01, 11/02, 11/03, 11/04, 11/05, 11/06, and 11/08/16.</p> <p>At 11:18 AM on 11/10/16 Nurse #1 stated she did administer PM doses of Flovent, Cosopt, Ambien, and calcium/vitamin D to Resident #129, but could not figure out how to document this administration in the e-MAR.</p>	F 514			



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F 514	Continued From page 24 In an interview with the Director of Nursing (DON) at 11:45 AM on 11/10/16 she stated she would not consider Resident #129's medical record to be complete and accurate since a nurse claimed she provided PM doses of Flovent, Cosopt, Ambien, and calcium/vitamin D, but this nurse reported she did not document the administration because she could not figure out how to enter it into the e-MAR.	F 514			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		12/9/16	

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F 520	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to Comprehensive Care Plans and Unnecessary Medications, which resulted in repeat citations at F279 and F329. The citing of F279 and F329 during the 09/29/16 complaint investigation (CI) and the facility's 11/10/16 annual recertification survey showed a pattern of the facility's inability to sustain an effective QA program. Findings included:</p> <p>This tag is cross - referenced to:</p> <p>F279 - Comprehensive Care Plan: Based on medical record review and staff interviews, the facility failed to develop a comprehensive care plan for 1 of 3 sampled residents (Resident #58) whose care plans were reviewed.</p> <p>F329 - Unnecessary Drugs: Based on physician interview, staff interview, and record review the facility failed to discontinue the administration of magnesium as ordered by the physician for 1 of 5 sampled residents (Resident #50) who was reviewed for unnecessary medications.</p> <p>At 1:10 PM on 11/10/16 the administrator stated on 09/29/16 the facility was cited for not implementing a medication dose reduction and for not completing a comprehensive care plan. He reported he was unsure why working these issues through the facility's QA process was not successful and led to F279 and F329 being re-cited.</p>	F 520	<p>The Quality Assurance and Performance Improvement (QAPI) committee met on 11/15/16 to discuss potential survey results to include discussion of repeat citations related to F279 and F329.</p> <p>The committee met on 11/30/16 and discussed final results of the annual survey. Discussion included actions already taken to correct procedures involved in the citations and plan for alleging compliance.</p> <p>The Division Director of Clinical Services and/or the Division Director of Operations will provide re-education to facility department managers and medical director regarding the Quality Assurance and Performance Improvement process on 12/8/16</p> <p>The Division Director of Clinical Services and/or the Division Director of Operations will attend QAPI meeting weekly times four and monthly times two if possible to ensure that plan of correction has been implemented and maintained. If either are unable to attend the meeting; minutes and supporting documentation will be emailed to them weekly by the administrator or director of nursing.</p> <p>The facility QAPI committee will meet weekly times four and monthly times two to discuss results of audits related to the plan of correction. the committee will analyze and trend the data to determine if</p>		

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F 520	Continued From page 26	F 520	revision to the plan of correction is needed.		