STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 01/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	**279 BRIAN CENTER DRIVE LEXINGTON, NC 27292**

(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 The surveyor entered the facility on 1/20/18 to conduct a complaint survey and exited on 1/21/18. Additional information was obtained on 1/22/18. Therefore, the exit date was changed to 1/22/18.	F 000		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		2/9/18

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

Electronically Signed | 02/05/2018

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F 842	Continued From page 1 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain complete and accurate accounting of the medication administration of	F 842	Company policy requires that facility clinical management (CM) must account for all controlled substance medications at	

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F 842	Continued From page 2 narcotics for 2 (Resident #1 and Resident #2) of 3 residents reviewed for accurate documentation. Findings included: 1. Resident #1 had an order for Xanax 1 mg tablet to be given every morning and at bedtime. The documentation in the Controlled Medication Utilization Record (CMUR) indicated Resident #1 was administered the last dose of Xanax from the medication cart on 11/24/17 at 8:00 PM. An "Orders- Administration" note for the Xanax dated 11/25/17 at 8:35 PM stated, "Pharmacy notified supply depleted." The documentation in the Medication Administration Record (MAR) indicated Resident #1 did not receive her bedtime dose of Xanax on 11/25/17. The documentation in the MAR indicated Nurse #1 administered the ordered dose of Xanax to Resident #1 at 8:00 AM on 11/26/17. Nurse #1 was interviewed on 1/22/18 at 11:43 AM. Nurse #1 stated she probably got the Xanax dose out of the backup but she did not remember Resident #1 or that particular medication administration. She stated it was possible the medication Xanax was not administered. An "Order - Administration" note for the Xanax dated 11/26/17 at 8:44 PM stated, "Need hard script." The documentation in the MAR indicated Resident #1 did not receive her bedtime dose of Xanax on 11/26/17. The documentation in the MAR indicated Nurse #2 administered the ordered dose of Xanax to Resident #1 at 8:00 AM on 11/27/17.	F 842	all times. Clinical management must document all doses of medication administered on the Medication Administration Record (MAR). CM is to initial the MAR only after the medication has been administered. When administering a controlled substance, the CM must also sign for the dose on the Resident-Specific Declining Inventory Record (also known as the Controlled Medication Utilization Record(CMUR). Based on the findings of the survey, CM failed to document administration of a controlled substance appropriately on all required forms. Resident #1 attending physician was notified on 1/21/18 of omitted documentation for Norco on medication order for 12/5/17, 12/6/17, 12/9/17, 12/23/17, 12/24/18, 12/29/17, 12/30/17, 12/31/17, and 1/1/18. The facility Director of Nursing completed medication variances for each date of omitted documentation. Resident #2 attending physician was notified on 1/21/17 of the omitted documentation for the administration of Oxycodone HCL on 1/13/18, 1/14/18, 1/21/18, 1/15/18, 1/18/18, and 1/19/18. The Facility Director of Nursing completed medication variances for each date of omitted documentation. The facility Director of Nursing will provide re-education regarding controlled medication documentation for nurse's 1,2,3,4,5 by 2/9/18.	

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F 842	Continued From page 3 Nurse #2 was interviewed on 1/22/18 at 10:45 AM. Nurse #2 stated she knew she pulled the dose of Xanax for Resident #1 from the back up supply in the facility. She stated she thought a utilization record of the medication pulled from the back up supply would prove she had taken the dose of Xanax from the back up supply. The Director of Nursing (DON) was interviewed on 1/22/18 at 10:15 AM. The DON stated that she had spoken with the pharmacy that morning. She stated it was the responsibility of the former DON to pull a report weekly from the back up supply utilization record and give it to the pharmacy for reconciliation. She stated this report had not been pulled by the former DON and the documentation to confirm the doses of Xanax for Resident #1 taken from the back up supply in November 2017 was unobtainable. Resident #1 had an order for Norco Tablet 5-325 mg 1 tablet by mouth given every 12 hours. Resident #1 also had an order for Norco Tablet 5-325 mg 1 tablet by mouth given every 6 hours as needed. The documentation in the CMUR on 12/4/17 indicated Nurse #3 administered the ordered dose of Norco to Resident #1 at 8:10 PM. The documentation in the CMUR also indicated Nurse #3 administered the ordered dose of Norco to Resident #1 at 8:00 PM. The documentation in the MAR on 12/4/17 indicated Nurse #3 administered a scheduled dose of Norco to Resident #1 at 8:00 PM and an as needed dose of Norco at 3:30 PM.	F 842	The facility clinical manager's (Director of Nursing and Unit Manager's) will complete an audit of the last 30 days medication records and Controlled Medication Utilization Record by 2/9/18 to ensure that narcotic medications that were documented as given are reflected on both documents. Any variances in the medication record and/or Controlled Medication Utilization Record will be documented on medication variance reports and the attending physician will be notified. The facility licensed nurses will be provided re-education by the Director of Nurses regarding controlled medication documentation 2/9/18. Any facility licensed nurse that does not receive re-education by completion date will not work until they have received re-education. Newly hired nurses will receive the education regarding medication documentation during orientation. The facility clinical managers will review 2 sampled residents on each unit receiving narcotics to ensure that medications are documented on the medications record and controlled medications utilization record daily for thirty days then bi-weekly times four weeks. The Director of Nursing will report the audit findings to the Quality Assurance Improvement committee monthly times three. The Quality Assurance Improvement Committee will evaluate the	

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F 842	Continued From page 4 Nurse #3 was interviewed on 1/21/18 at 9:38 AM. Nurse #3 stated she did not give Resident #1 two doses of Norco at 8:00 PM and 8:10 PM on 12/4/17. Nurse #3 stated, "Something must have been going on for me to make a time error on the Narc sheet (CMUR)." The documentation in the CMUR indicated Nurse #4 administered as needed doses of Norco to Resident #1 on 12/5/17 at 4:00 PM, 12/6/17 at 4:00 PM, 12/23/17 at 3:30 PM, 12/24/17 at 4:00 PM, 12/29/17 at 3:30 PM, 1/1/18 at 4:00 PM, and 1/2/18 at 4:30 PM. There was no documentation on the MAR to indicate Nurse #4 administered the as needed doses of Norco to Resident #1 on those days and administration times. Nurse #4 was interviewed on 1/22/18 at 10:30 AM. Nurse #4 stated that if she signed the CMUR, then the medication Norco was given to Resident #1 on those dates and times. Nurse #4 stated that the facility was having issues with the computer system in December 2017 and the hall on which Resident #1 resided was very busy, causing her to not document administration on the MAR. The documentation in the CMUR indicated Nurse #5 administered as needed doses of Norco to Resident #1 on 12/6/17 at 3:00 AM, 12/20/17 at 2:50 AM, 12/29/17 at 3:00 AM, and 1/2/18 at 3:00 AM. There was no documentation on the MAR to indicate Nurse #5 administered the as needed doses of Norco to Resident #1 on those days and administration times.	F 842	results and implement additional interventions as needed to ensure continued compliance.	

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Nurse #5 was not available for an interview due to her health.

The documentation in the CMUR indicated Nurse #6 administered an as needed dose of Norco to Resident #1 on 12/9/17 at 4:00 AM.

There was no documentation on the MAR to indicate Nurse #6 administered the as needed dose of Norco to Resident #1 on 12/9/17 at 4:00 AM.

Nurse #6 was interviewed on 1/22/18 at 5:38 AM. Nurse #6 stated she had missed documenting on the MAR on 12/9/17 at 4:00 AM for Resident #1 on accident. She stated she definitely gave the medication but was maybe distracted and did not document on the MAR.

The documentation in the CMUR indicated Nurse #7 administered as needed doses of Norco to Resident #1 on 12/30/17 at 3:00 PM and 12/31/17 at 4:00 PM.

There was no documentation on the MAR to indicate Nurse #7 administered the doses of Norco to Resident #1 on 12/30/17 at 3:00 PM and 12/31/17 at 4:00 PM.

Nurse #7 was interviewed on 1/21/18 at 8:43 AM. Nurse #7 stated the medication Norco was absolutely given to Resident #1 on those dates and administration times. Nurse #7 stated it was likely a documentation issue on her part.

The DON was interviewed on 1/21/18 at 12:42 PM. The DON stated her expectation was for the nurses to fill out the CMUR after giving a narcotic

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F 842	Continued From page 6	F 842		

to a resident and as soon as possible sign the narcotic was administered on the MAR.

2. Resident #2 had an order for one tablet of Oxycodone HCL 10 mg to be given by mouth every 4 hours as needed.

The documentation on the Controlled Medication Administration Record (CMUR) indicated Nurse #5 administered a dose of Oxycodone HCL to Resident #2 on 1/13/18 at 3:00 AM.

There was no documentation on the Medication Administration Record (MAR) to indicate Nurse #5 administered a dose of Oxycodone HCL to Resident #2 on 1/13/18 at 3:00 AM.

Nurse #5 was not available for an interview due to her health.

The documentation on the CMUR indicated Nurse #7 administered a dose of Oxycodone HCL to Resident #2 on 1/13/18 at 9:00 PM, 1/14/18 at 6:00 PM, and 1/14/18 at 10:00 PM.

There was no documentation on the MAR to indicate Nurse #7 administered doses of Oxycodone HCL to Resident #2 on those dates and times.

Nurse #7 was interviewed on 1/21/18 at 8:43 AM. Nurse #7 stated the Oxycodone was absolutely given to Resident #2 on those dates and administration times. Nurse #7 stated it was likely a documentation issue on her part.

The documentation in the CMUR indicated Nurse #8 administered doses of Oxycodone HCL to Resident #2 on 1/14/18 at 8:00 AM, 1/14/18 at

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2:00 PM, and 1/18/18 at 9:00 AM.

There was no documentation on the MAR to indicate Nurse #8 administered the doses of Oxycodone HCL to Resident #2 on those dates and administration times.

Nurse #8 was not interviewed due to a lack of contact information.

The documentation on the CMUR indicated Nurse #4 administered doses of Oxycodone HCL to Resident #2 on 1/15/18 at 3:30 PM, 1/16/18 at 5:00 PM, 1/17/18 at 3:00 PM and 1/17/18 at 7:00 PM.

There was no documentation on the MAR to indicate Nurse #4 administered doses of Oxycodone HCL to Resident #2 on those dates and administration times.

Nurse #4 was interviewed on 1/22/18 at 10:30 AM. Nurse #4 stated that if she signed the CMUR, then the medication Hydrocodone HCL was given to Resident #2 on those dates and times. Nurse #4 stated that the facility was having issues with the computer system in December 2017 and the hall on which Resident #2 resided was very busy causing her to not document administration on the MAR.

The documentation on the CMUR indicated Nurse #9 administered doses of Oxycodone HCL to Resident #2 on 1/18/18 at 5:00 AM, 1/17/18 at 12:15 AM, 1/17/18 at 5:00 AM, 1/18/18 at 10:30 PM, and 1/19/18 at 3:00 AM.

There was no documentation on the MAR to indicate Nurse #9 administered doses of

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Oxycodone HCL to Resident #2 on those dates and administration times.

Nurse #9 was interviewed on 1/22/18 at 5:20 AM. Nurse #9 stated she gave the doses of Oxycodone HCL to Resident #2 if it was on the CMUR. Nurse #9 stated she tried to document on the MAR but on those occasions she did not.

The documentation on the CMUR indicated Nurse #10 administered doses of Oxycodone HCL to Resident #2 on 1/17/18 at 9:15 AM and 1/18/18 at 1:03 PM.

There was no documentation on the MAR to indicate Nurse #9 administered doses of Oxycodone HCL on those dates and administration times.

Nurse #9 was interviewed on 1/21/18 at 12:14 PM. Nurse #9 stated she did administer the doses of Oxycodone HCL to Resident #2 if she documented the administration on the Narc sheet (CMUR). She stated that maybe she did not save the administration time on the MAR and therefore it did not show she gave the medication.

The documentation on the CMUR indicated Nurse #3 administered a dose of Oxycodone HCL to Resident #2 on 1/18/18 at 5:45 PM.

There was no documentation on the MAR to indicate Nurse #3 administered a dose of Oxycodone HCL to Resident #2 on 1/18/18 at 5:45 PM.

Nurse #3 was interviewed on 1/21/18 at 9:38 AM. Nurse #3 stated she gave the dose of Oxycodone HCL to Resident #2 if she documented it on the

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F 842	Continued From page 9 CMUR. The Director of Nursing (DON) was interviewed on 1/21/18 at 12:42 PM. The DON stated her expectation was for the nurses to fill out the CMUR after giving a narcotic to a resident and as soon as possible sign the narcotic was administered on the MAR.	F 842		