STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION (XX)	MB NO, 093 DATE SURVEY COMPLETED
1144		345011	B. WING	11.00 -4 2011	06/09/201
	PROVIDER OR SUPPLIER CENTER NURSING C	ARE/LEXI	271	ET ADDRESS, CITY, STATE, ZIP CODE DERIAN CENTER DRIVE EXINGTION, NC 27292	
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	ASSESSMENTS  The facility must of a comprehensive, reproducible assess functional capacity  A facility must mak assessment of a received assessmen	onduct initially and periodically accurate, standardized sment of each resident's see a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; patterns; seing; and structural problems; and health conditions; al status; and procedures; ummary information onal assessment performed ingered by the completion of	F 272	1. Corrective action has been accomplished for the alleged deficient practice in regards to timely comprehensive assessmen related to Resident #154 and #16 by completion of the comprehensive assessments by the MDS Coordinator on June 15, 2011.  2. Facility residents having the potential to be affected by the same alleged deficient practice were identified through review of the MDS roster report, validation transmission reports and a chart audit of comprehensive assessments completed since May 1, 2011, by the Interdisciplinary Team including the Director of Nursing (DON), Unit Managers and MDS Coordinator and completed for transmission.  "Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."	50

Any deficiency statement ending with an asserisk (\*) 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 discloseble 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 discloseble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is regulate to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YCFU11

Facility ID: 923005

if continuation sheet Page 1 of

		AND HUMAN SERVICES			FORM	): 06/16/i 1 APPRO 0. 0938-0
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
_		345011	B. WING_		06/	09/2011
NAME OF F	PROVIDER OR SUPPLIER		этг	REET ADDRESS, CITY, STATE, ZIP CO	<del></del>	<u>, , , , , , , , , , , , , , , , , , , </u>
BRIAN C	ENTER NURSING CA	RE/LEXI	E .	79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
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F 272	Continued From pa	g <b>e</b> 1	F 272	3. Measures put into plac that the alleged deficie does not recur include re-education for	nt practice	
	by:	IT is not met as evidenced		members of the Interdisciplinary team, regarding MDS assess		
	review, the facility fa admission minimum	view and medical record alled to complete an data set (MDS) assessment esidents (Resident #154 and		completion requirement DON and the Region C Management Coordina audit of the MDS due	nts by the Care ator. An	
	Resident #160). The findings are:			will be provided by the Home Administrator (i and reviewed and com	Nursing VH.4), pared to	
	diagnosis including	is admitted on 5/23/11 with Diabetes Mellitus Type II, ne and a history of falls.		the MDS calendar dail comprehensive assess due, also provided by t for a period of 4 weeks	nents the NHA	
÷	Review of the Cogni by the Social Worke	tion Assessment completed r on 5/30/11 revealed the te cognitive impairment.		IDT including the Dir Nursing (DON), Assist Director of Nursing (A Unit Managers and M	ector of ant DON),	
ŀ		#154's medical record ensive Assessment was not		Coordinator to assure completion of comprel assessments as well as	timely nensive care area	
	Interview with the M	DS Coordinator on 6/9/11 at at given Resident #154 was		assessments. Any ider discrepancies will be documented on the ML calendar and the asses	OS due	
1	Date (ARD - the date back period) would it 6/5/11 would have b	her Assessment Reference that is the end of the look have been 5/30/11 and sen the 14th day, or the day		will be completed by the ADON, or MDS muss/coordinator upo identification.	he DON,	
	assessment was due completed. The MD the data to complete	S Coordinator Indicated that all sections of the MDS had		"Preparation and/or execution of plan of correction does not con admission or agreement by the provider of the truth of the fact	stitute s	
	the data had not yet data base and was o that as a result of the	the look back period but been entered into the MDS verdue. He further indicated MDS not being completed lired schedule, the Care		alleged or conclusion set forth statement of deficiencies. The correction is prepared and/or ex solely because it is required by provisions of federal and state	plan of xecuted	

DEPAR	RTMENT OF HEALT	H AND HUMAN SERVICES E & MEDICAID SERVICES				FOR	M APPRO
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) N		LTIPLE CONSTRUCTION	OMB NO, 0938-1 (X3) DATE SURVEY COMPLETED	
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_	PROVIDER OR SUPPLIER CENTER NURSING CA	ARE/LEXI			TREET ADDRESS, CITY, STATE, ZIP CODE 278 BRIAN CENTER DRIVE LEXINGTON, NC 27292		5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREFI TAG	IX.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	XULD BE	(X5) COMPLET DATE
F 272	Area Assessments  During the interview indicated that the fa Coordinators but the vacant since 5/9/11 Coordinator is not a	had also not yet been written.  v, the MDS Coordinator collity usually has two MDS e other position has been and the new MDS evailable until 7/5/11.	F2	272	This comparison will be n during the Monday – Frida morning meeting to include Social Services, Rehab Manager, MDS Nurse/Coordinator, DON, Dietary Manager and Activ Director.	v :	
	6/9/11 at 1:15 PM n was put in place to completion of MDS assessments were with Regional MDS or staff from another this facility 2 - 3 day the MDS Assessme  Review of the (namedated 6/3/11 revealed 100 percentage)  " Description of issuessessments, " Admissions for the interpretage in	e of facility) MDS Action Plan			4. Data obtained during audits be analyzed for patterns/trer and reporting in Quality Assessment and Assurance (QA&A) meeting, weekly for period of 4 weeks, monthly a period of 3 months and the randomly thereafter. The QA&A Committee will evaluate the effectiveness of plan and will adjust the plan, needed based on trends identified to ensure continued compliance.	or a for n	
	of compliance - scho assessments for cor (interdisciplinary tea assistance from (3 c	edule most out of date MDS npletion by the IDT			5. Date of Compliance: July 1, 2011		
	11:38 indicated that residents currently in Comprehensive Admiwere not completed period for new Admi Two of these resider	DS Coordinator on 6/9/11 at there were 4 new admit the facility who's nission MDS assessments within the 14 day compliance ssion MDS assessments. Its were sampled residents, or stated that there were no			"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."	THE PARTY AND TH	

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STATEMENT AND PLAN OF PRESENT AND PLAN OF PRESENT TAG  F 272 (3 c) as 2 c) as 3 c) as	,	MDS assessments that were	F 2	72			
	Review of the Cogni by the Social Worke	as admitted on 5/25/11, ition Assessment completed r on 5/30/11 revealed the cognitive impairment.					
	Review of Resident in revealed a Compreh present on the chart.	#160's medical record ensive Assessment was not					
	1:00 PM revealed the admitted on 5/25/11, Date (ARD - the date back period) would he would have been the which the Comprehe assessment was due completed. The MDS the data to complete been gathered during the data had not yet it data base and was outhat as a result of the according to the requared Assessments had	S Coordinator indicated that all sections of the MDS had the look back period but been entered into the MDS verdue. He further indicated MDS not being completed ired schedule, the Care and also not yet been written.					
	indicated that the faci	the MDS Coordinator lity usually has two MDS other position has been and the new MDS iilable until 7/5/11.				The state of the s	
1	nterview with the Reg	ional MDS Coordinator on					

CENT	LEGO EOD MEDIOVEI	H AND HUMAN SERVICES					D: DE/TE MAPPRE
ETAN	ERS FOR MEDICARI	& MEDICAID SERVICES					O. 0938
WOPLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345011	B. WIN	ю <u>_</u>			
NAME OF	PROVIDER OR SUPPLIER		<del></del>			06/	09/2011
	CENTER NURSING CA	REALEXI		27	eet address, city, state, zip code 9 Brian center drive Exington, NC 27292	i	
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F 312 SS=D	6/9/11 at 1:15 PM re was put in place to a completion of MDS assessments were was the Regional MDS or staff from another this facility 2 - 3 day the MDS Assessment Review of the (name dated 6/3/11 reveale "Description of Issue assessments." "A admissions for the lacurrent), Identify MD of compliance - sche assessments for compliance - sche assessments for completion date for the Interview with the ME 11:38 indicated that the residents currently in Comprehensive Admistration of these resident The MDS Coordinato Significant Change Moverdue; Annual and assessments were not 483,25(a)(3) ADL CANDEPENDENT RESID	evealed that an action plant ensure accurate and timely assessments and that MDS within the regulatory window. Coordinator stated that she readily had been coming to a week to help complete ints.  To of facility) MDS Action Planted, in part:  The case of timely MDS action Items; Audit of new lest 30 days (May through Stassessments that are out included most out of date MDS inpletion by the IDT in) - schedule MDS in the facilities listed). The hese items was 6/10/11.  The facility who's included in the facility who's included in the series assessments within the 14 day compliance sion MDS assessments. It were sample residents. It is were sample residents. It stated that there were no IDS assessments that were Quarterly MDS it discussed.  RE PROVIDED FOR ENTS	F 2				
	daily living receives the	ble to carry out activities of ne necessary services to n, grooming, and personal					

		HAND HUMAN SERVICES				FOR	D: 06/16/ M APPRO
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:	(92) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	s		ESS, CITY, STATE, ZIP CODE		09/2011
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	This REQUIREMENty: Based on record relinterview, the facility incontinence care to sampled residents. The facility's policy of was reviewed. The female patient read bend her knees slight Separate her labia with the other, using gent the front to the back intestinal organism for urethra or vagina. A anus end use a clear each stroke by folding prevents the spread or discharge. Using thoroughly from from residue can cause skin initiation a ordered ointments or her skie to Sim's postine anal area. Clean area, starting at the pand wiping from front Resident # 29 was or facility on 08/16/09 w	view, observation and staff of failed to provide proper 1 (Resident #29) of 3 The finding includes:  on Perineal Care (undated) Perineal care policy for the in part " Ask the patient to only and to spread her legs, with one hand and wash with the downward strokes from of the perineum to prevent rom contaminating the void the area around the on section of wash cloth for it geach section inward. This of contaminated secretions a clean washcloth, rinse it to back because soap the irritation. Pat the area because moisture can also and discomfort. Apply a creams. Turn the patient on ition, if possible to expose the irritation of the perineum to prevent on the patient on ition, if possible to expose the irritation of the patient on ition, if possible to expose the patient of the patient	F 31:	"Pre corr agree facts state corre beca	Corrective action has been accomplished for the alleged deficient practice in regards to resident #29 regarding inappropriate incontinent care providing one to one return demonstration training with the identified caregiver by DON June 8, 2011	s by  g ntial  t  s h aff DN  is plan of sion or oth of the in the of ed solely	7-1-1
		lis, Aortic Aneurism, xiety, Hypertension,				?	•

DEPAF	RTMENT OF HEALT	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 06/16 M APPRO
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BRIAN	CENTER NURSING CA	ARE/LEXI		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	,002	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	COMPLE DATI
	Alzheimer's disease Disease (GERD) as Data Set (MDS) as (assessment refere Resident #29 was oneeded extensive a The care plan dated One of the approace provide incontinent episode or per estated by NA #1 (incontinent episode to be soiled with uniobserved to provide brought in two wash be used during the laprepared a wash ba bedside. NA #2 car started by cleaning and the inner thigh a washcloth was observed to use the stool in it. NA #1 was the labia to clean it, her side. NA #1 progression and to clean it, her side.	e, Gastro esophageal Reflux and Depression. The Minimum sessment dated 05/07/11 ance date) indicated that cognitively impaired and assist with hygiene/grooming.  I 06/06/11 was reviewed. These to the care plan was "to care after each incontinent blished tolleting plan".  I PM, Resident #29 was abserved the incontinent care. She acloths and one bath towel to incontinent care, She sin with water and soap at the incontinent care, She sin with water and soap at the front part of the perineum using the washcloth. The rived to have stool in it. She cloth and continued cleaning nother washcloth. The as again observed to have in not observed to separate to ceeded to clean the analing washcloth. NA #1 was same washcloth to remove in the analiarea. After the used the bath towel to pat was observed to dry the ghs using the towel. NA #1 the towel several times to en the resident's thighs. The	F 31	that the alleged deficie does not recur include peri-care audits to be p by the Staff Developm DON, ADON and Unit 10 random incontinent will be conducted weel period of 4 weeks, then 4 audits will be conducted shift. 4 audits will be conducted shift and 2 audits shift weekly. Residents chosen according to the assessment and rotated residents are observed, audits will be documen Male/Female Skills Ch. List. Incontinent care e has been included in the orientation of new lices.  4. The DON and ADON data obtained during in observations, analyzing patterns and trends, and monthly Quality Asses Assurance Committee weekly for a period of then monthly. The about be adjusted as needed to continued compliance.  5. Date of compliance: July 1, 2011  "Preparation and/or execution of correction does not constitute at agreement by the provider of the facts alleged or conclusion set if statement of deficiencies. The protection is prepared and/or execution is prepared and/or execution is required by provision and state law."	nt practice random erformed ent Nurse, t Managers. care audits kly for a n monthly. red on first conducted on its on third will be e last MDS I so that all Proof of ted on the eck Off ducation e nsed staff.  will review continent care g to identify I reporting in sment and meeting 4 weeks, and ove plan will o ensure  f this plan of dimission or e truth of the orth in the olan of ecuted solely	

CENTE	RS FOR MEDICARE	HAND HUMAN SERVICES				FOR	D: 08/16/ RM APPRC IO, 0938-1
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1	PROVIDER OR SUPPLIER CENTER NURSING CA	RE/LEXI	<b>!</b>	s	STREET ADDRESS, CITY, STATE, ZIP COE 278 BRIAN CENTER DRIVE LEXINGTON, NC 27292		<del>//09/2011</del>
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	towel was observed every time she wipe overy time she wipe On 06/07/11 at 4:19 NA #2 explained here care to a female resimportance of separthe inside from front looks clean. She ach not follow the proper care by not separation acknowledged that the cleaned due to the bresident has yellowis wiped it to the area to the discounty two washed the original to dry the resident's story the re	to have a yellowish color of the area.  PM, NA #2 was interviewed, who do proper incontinence ident. She emphasized the ating the labia and cleaning to back until the washcloth knowledged that NA #1 did reprocedure for incontinenceing the labia. She also the resident was not properly eath towel used to dry the she color every time she between the resident's thighs.  PM, NA #1 was interviewed, that she did not separate the clean the perineum from the lowledged that she has to onthe because they ran out at that the resident was not because the bath towel used skin was yellowish in color the area between the	F3	31:			

DEPARTI CENTERS	MENT OF HEALTH AND HUMAN SERVICES S FOR MEDICARE & MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·	HAN EZ
STATEMEN NO HARM ' FOR SNP .	IT OF ISOLATED DEFICIENCIES WHICH CAUSE WITH ONLY A POTENTIAL FOR MINIMAL HARM AND NP#	PROVIDER # 345011	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE:
ľ	ROVIDER OR SUPPLIER ENTER NURSING CARE/LEXI	STREET ADDRESS, C 279 BRIAN CENT LEXINGTON, NO	ITY, STATE, ZIP CODE TER DRIVE	6/9/2011
ID PREFTX TAG	SUMMARY STATEMENT OF DEFICIEN			
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO I  The resident has the right, unless adjudg laws of the State, to participate in planni  A comprehensive care plan must be deve assessment; prepared by an interdisciplin with responsibility for the resident, and c needs, and, to the extent practicable, the legal representative; and periodically rev	ted incompetent or cing care and treatment of the care and treatment of the care, that includes appropriate standardination of the carticipation of the care.	otherwise found to be incapacitated unent or changes in care and treatment.  after the completion of the comprehences the attending physician, a register of the disciplines as determined by the	nsive red nurse resident's
	This REQUIREMENT is not met as evid Based on record review and staff interview residents (Resident #94).  The findings included:	enced by: v, the facility failed	to update a care plan for 1 of 15 samp	oled
	Resident #94 was admitted to the facility of that the resident had fallen at the assisted fracture,	on 2/9/11. The hosp living facility where	ital discharge summary dated 2/9/11 r she resided and she sustained a wrist	evealed
	The admission Minimum Data Set (MDS) discharged to the community.	dated 2/16/11 indic	ated that Resident #94's goal was to b	e
	Resident #94's care plan for discharge, date milestones required for discharge in the ne discharge.	ed 3/4/11, revealed xt 90 days. Approac	a goal of progressing towards or reach thes included a home evaluation prior	uing to
	Physical Therapy notes dated 4/14/11 - 4/2 4/21/11 with a physical therapist and a far revealed that the resident cancelled the honterm care.	lilv member. Physia	Cal Theranu notee doted 4/91/11 4/97	r/1 1
	Social Progress Notes dated 5/5/11 indicate	d that Resident #94	and her family decided on permanent	:

Any deficiency statement ending with an exterisk (\*) 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 musting homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For musting homes, the showe 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

The above isolated deficiencies pose no actual furm to the residents

placement at the facility.

DEPARTMENT CENTERS FO	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			A) "A" FORI					
	OF ISOLATED DEFICIENCIES WHICH CAUSE HONLY A POTENTIAL FOR MINIMAL HARM ONE	PROVIDER # 345011	MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	DATE SURVEY COMPLETE: 6/9/2011					
1	vider or supplier TER nursing care/lexi	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	√CIES							
F 280	Continued From Page 1								
	Resident #94's quarterly MDS dated 5/8 resident to return to the community and community.	//11 indicated there w no determination ha	as no active discharge plan in place for the second to the	or the se					
	Resident #94's care plan for discharge included a statement dated 5/12/11 to continue plan of care and did not reflect the resident's decision to permanently reside at the facility.								
	During an interview on 6/9/11 at 8:45 AM, the Social Worker (SW) acknowledged that Resident #94's care plan did not reflect the resident's current plan to live at the facility. The SW indicated that she herself did not update care plans; rather she discussed residents with the MDS nurses who in turn updated the care plans.								
	During an interview on 6/9/11 at 9:30 A #94 had decided to permanently reside a updated by other staff members, not just	t the facility. The MI							
	•								

PRINTED: 07/05/2011 SEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING 07/01/2011 345011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 279 BRIAN CENTER DRIVE **BRIAN CENTER NURSING CARE/LEXI** LEXINGTON, NC 27292 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 062 K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Correction for the item noted as "corroded Required automatic sprinkler systems are sprinklers underneath canopy-located continuously maintained in reliable operating behind staff breakroom": will be cleaning condition and are inspected and tested of the sprinklers affected so that periodically. 19.7.6, 4.6.12, NFPA 13, NFPA temperature sensing element will be clean 25, 9.7.5 and readily visible as to temperature color and reliability. The Maintenance director will survey the remainder of the canopies and clean any additional sprinklers upon This STANDARD is not met as evidenced by: discovery with any negative findings Based on observation, on July 1, 2011 at reported to the Administrator approximately 1:00pm, there are corroded immediately. The Maintenance Director sprinklers underneath canopy - located behind will continue weekly observations of staff breakroom. sprinklers for the next three months with monthly inspections continuing thereafter. 42 CFR 483,70(a) All results will be reported to and K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 discussed at monthly Safety committee SS=F meetings for the next three months and Electrical wiring and equipment is in accordance continue quarterly thereafter until next with NFPA 70, National Electrical Code. 9.1.2 annual survey. Completion date of July 28, 2011. This STANDARD is not met as evidenced by: Based on observation, on July 1, 2011 at approximately 8:00am onward, the electrical system is noncompliant due to the following: 1, unsecured emergency receptacle - corridor wall between room 202, and unit coordinator office.

ABORATORY DIRECTOR'S OR PROVIDEN/SUPPLIER REPRESENTATIVE'S SIGNATURE

2. loss of normal power to automatic transfer switch number one did not cause activation of the

generator power indicator, located on the annunciator panel, with transfer switch in

emergency mode.

Facility ID: 923005

CONSTRUCTION

(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.

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

PRINTED: 07/05/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SI COMPLE		
	,	345011	B. WIN	IG		07/0	1/2011	
	ROVIDER OR SUPPLIER ENTER NURSING CA	ne/Lexi		27	EET ADDRESS, CITY, STATE, ZIP CODE 79 BRIAN CENTER DRIVE EXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE OPRIATE	(X5) COMPLETION DATE	
K 147	Continued From pa 42 CFR 483.70(a)	ge 1	K	147	Correction for the item noted as (1) "unsecured emergency receptacle between room 202 and Unit manage office" was to immediately tighten a secure as needed.  Maintenance director will survey the remainder of the building to determing like instances and repair upon discovery. Maintenance director will continue weekly checks during normounds ongoing. Any negative finding will be reported to the Administrator immediately and all findings will be reported to and discussed during mosafety Committee meetings for the reference months and continue quarterly thereafter until next annual survey. Completion date of July 1, 2011. (2) Correction for item noted as "transfesswitch number one did not cause activation of generator power indicates was to immediately contact generator contractor to inspect system and determine all lighting functioning properly. All systems functioned properly. All systems functioned properly and additional label was added to expanels to clarify proper lighting. The Maintenance Director will observe proper testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next through some contractor testing and report to Administrator.	r nd ne ll nal ngs . nthly next or tor": or y sting e oroper y	7-28-11	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES INTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
MADICAN	F CORRECTION	IDENTIFICATION HOMBER	A. BUILDI	NG 01 - MAIN BLDG		
		345549	B. WING _		06/3	0/2011
NAME OF P	ROVIDER OR SUPPLIER		,	REET ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SAL HEALTH CARE /	BRUNSWICK		1070 OLD OCEAN HIGHWAY		
Onividin				BOLIVIA, NC 28422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE ROPRIATE	(X5) COMPLETION DATE
				Preparation and / or execution	of this	
K 025	NFPA 101 LIFE SA	FETY CODE STANDARD	K 025			
SS=D				admission or agreement by the		
		constructed to provide at		of the truth of the facts alleged	or	
		e resistance rating in		conclusion set forth in the state	ement of	
	accordance with 8.	3. Smoke barriers may		deficiencies. The plan of correc	tion is	
	terminate at an auti	um wall. Windows are led glazing or by wired glass		prepared and / or executed sol		
	protected by irro-ra	frames. A minimum of two		because it is required by provis		* •
	separate compartm	ents are provided on each		state and federal law.		
	floor. Dampers are	not required in duct				
		oke barriers in fully ducted		K 025		!
	heating, ventilating,	and air conditioning systems.		No residents were adversely af	fected by	
	18.3.7.3.163.00			the alleged deficient practice.		
ļ		ן שר		the aneged denotes product		
	ال	儿 1 8 2011		All residents residing within the	e facility	
				have the potential to be affected	ed by the	
. !	L	NOTION OF OTION				
		RUCTION SECTION		alleged deficient practice. All si		
	This STANDARD i	s not met as evidenced by:		walls within the facility attic are		
	Based on observal	ion on Thursday 6/30/2011		inspected to identify if there w		
	noted:	and 1:00 PM the following was		other PVC pipes penetrating th		
		located in the attic area on 300		wall and not equipped with a U	it rated	<u> </u>
		penetrating the smoke wall that		fire stop assembly.		† •
	are not equipped w	ith an UL rated fire stop			•	
	assembly.			Any pipe that penetrates the si		
	42 CFR 483.70		14.050	wall not having UL rated fire st	•	
	NFPA 101 LIFE SA	FETY CODE STANDARD	K 056	COSCILIOIS ASILI LIGITO CITO COSCILIO		
SS=D	The series are automore	tic aprinkler system installed		installed by our Maintenance [	irector.	
	in eachdana with	itic sprinkler system, installed NFPA 13, Standard for the		1		
	In accordance with	kler Systems, with approved		The Maintenance Director will	inspect	
	. components, devic	es, and equipment, to provide		/audit the fire walls monthly X	3	
	complete coverage	of all portions of the facility.		months to ensure that all PVC		•
	The system is main	itained in accordance with		penetrating the smoke walls a		
	NFPA 25, Standard	I for the Inspection, Testing,		equipped with the fire stop ass		<u> </u>
	and Maintenance o	f Water-Based Fire Protection		This audit will be brought to th		08/05/11
	Systems. There is	a reliable, adequate water		monthly QA meeting for 3 mor		08/03/11
ABORATOR	V DIDECTORS OF PROVIE	DEBISHIPPHER REPRESENTATIVE'S SIGN	VATURE	TITLE		(X6) DATE
VPOKH LOK	, DIRECTORS OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN				

Administrator

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.

Facility ID: 050908

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

PRINTED: 07/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION TO MODELS	A. BUILDII	NG 01 - MAIN BLDG			
		345549	8. WING		06/30/2011		
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE / BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422				
(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	
K 056 K 061 SS=F	with waterflow and connected to the firm to connected to the firm.  This STANDARD is Based on observation between 9:30 AM anoted:  1) Throughout the frescutcheon around set into the ceiling tit and the ceiling. 42 CFR 483.70 NFPA 101 LIFE SA Required automatic valves supervised swill sound when the 72, 9.7.2.1  This STANDARD is Based on observation between 9:30 AM anoted:  1) The two sprinkles with accelerators the	m. The system is equipped tamper switches which are e alarm system. 18.3.5.  Is not met as evidenced by: ion on Thursday 6/30/2011 and 1:00 PM the following was acility the sprinkler the sprinkler heads were not to seal off all openings betweet FETY CODE STANDARD is sprinkler systems have to that at least a local alarm evalves are closed. NFPA is not met as evidenced by: ion on Thursday 6/30/2011 and 1:00 PM the following was ar riser systems are equipped at have gate valves between it is not equipped with an	K 056	the alleged deficient practice.  All residents have the potential affected by the alleged deficient practice. All sprinkler escutches around the sprinkler heads we inspected to be sure they were to the ceiling. All that were found be sealed were repaired to ensure the openings between it a ceiling.  The Maintenance Director will all sprinkler heads on a month throughout the building to ensure the sealed were the ceiling.	I to be nt eon plates re e sealed und to not sure there and the linspect ly basis sure that en the ate. If any unplete at the rought to	08/05/11	

### PRINTED: 07/05/2011 RTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A BUILDING 01 - MAIN BLDG B. WING 345549 06/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1070 OLD OCEAN HIGHWAY UNIVERSAL HEALTH CARE / BRUNSWICK BOLIVIA, NC 28422 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY

### K 061

No residents were adversely affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice. BFPE International has been contracted to install two ball type supervisory switches located on two Dry System Accelerators on the isolation control valves. BFPE will add two additional monitoring modules to the fire alarm system for monitoring of the supervisory switches.

The Maintenance Director will inspect the risers weekly, BFPE will inspect the sprinkler system quarterly and annually BFPE will inspect the fire alarm panel to ensure compliance with our fire alarm sprinkler and monitoring systems.

The Maintenance Director will bring the results of his inspection and the inspections by BFPE to the monthly QA meeting for 3 months.

08/05/11

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.

July 14, 2011

Jeffrey Waddell, Engineer
NC Department of Health and Human Services
Division of Health Service Regulation
Construction Section

Re: Brian Center Nursing Care/Lexington
Plan of Correction, Credible Allegation of
Compliance, and Request for Re-survey

Dear Mr. Waddell,

On July 1, 2011, surveyor from NC Department of Health and Human Services Division of Health Service Regulation Construction Section completed an inspection at Brian Center Nursing Care/Lexington. As a result of the inspection, the surveyor alleged that the Facility was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the Statement of Deficiencies (CMS-2567) with the Facility's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Facility of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.

Please also consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The facility will achieve (or has achieved) substantial compliance with the applicable certification requirements on or before August 15, 2011. Please notify me immediately if you do not find the Plan of Correction to be written credible evidence of the Facility's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with additional evidence of compliance so that you may certify that the facility is in substantial compliance with the applicable requirements.

This letter is also our request for re-survey, if one is necessary, to verify that the Facility achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance with this matter. Please call me if you have any questions.

Yours truly,

Shonda Wingate Administrator

# WEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2011 FORM APPROVED OMB NO. 0938-0391\_

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345011	B, WING _	<u> </u>	07/0	01/2011
	PROVIDER OR SUPPLIER	ME/LEXI	2	REET AODRESS, CITY. STATE, ZIP CON 179 BRIAN CENTER DRIVE .EXINGTON, NC 27292	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
	Required automatic continuously maints condition and are in periodically. 19.7 25, 9.7.6  This STANDARD is Based on observat approximately 1:00 sprinklers undernesstaff breakroom.  42 CFR 483.70(a) NFPA 101 LIFE SA Electrical wiring and with NFPA 70, National Passed on observation approximately 8:00 system is noncompled. unsecured emergents of the periodical system is noncompled.	sprinkler systems are ained in reliable operating aspected and tested .6, 4.6.12. NFPA 13, NFPA so not met as evidenced by: aion, on July 1, 2011 at pm, there are corroded ath canopy - located behind sequipment is in accordance ional Electrical Code. 9.1.2 and met as evidenced by: aim onward, the electrical liant due to the following: gency receptacle - corridor 202, and unit coordinator	ANDARD K 062 s are perating ed 13, NFPA enced by: 11 at roded ed behind NDARD K 147 accordance de. 9.1.2 enced by: 1 at ectrical lowing: corridor	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION OATE
	switch number one of generator power ind	wer to automatic transfer did not cause activation of the icator, located on the vith transfer switch iก	To proper proper to the second			
		EGICLIDOLIGO DADDECOMYATINE'S CICA		* AlAts >	····· - +	/X6LDATE

Any deficiency statement anding with an asterist (") denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards 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.

FORM CMS-2587(02-99) Provious Versions Obsolete

Event ID, YCFU21

Facilly ID: 923005

If continuation sheet Page 1 of 2

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

PRINTED: 07/05/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 MAIN BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED		
		345011				07/01/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 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)		PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO		Provider's Plan of Correi) (Each Corrective Action Sh() Cross-Referenced to the Appr Deficiency)	ON SHOULD BE COMPLETION HE APPROPRIATE COMPLETION	
K 147	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K	147	K147 Correction for the item noted as (1)"unsecured emergency receptacle between room 202 and Unit manage office" was to immediately tighten a secure as needed.  Maintenance director will survey the remainder of the building to determine any like instances and repair upon discovery. Maintenance director with continue weekly checks during normal rounds ongoing. Any negative finding will be reported to the Administrator immediately and all findings will be reported to and discussed during more safety Committee meetings for the atthree months and continue quarterly thereafter until next annual survey. Completion date of July 1, 2011. (2) Correction for item noted as "transfer switch number one did not cause activation of generator power indicates was to immediately contact generate contractor to inspect system and determine all lighting functioning properly. All systems functioned prand additional label was added to expand to clarify proper lighting. The Maintenance Director will observe princation of all lighting during weeks generator testing and report to Administrator.  All findings to the monthly Safety Committee meetings for the next the months and continue quarterly there until next annual survey. Completic of July 8, 2011.	or and  ine  li nai ings  r  inthly next  operly tisting in the proper is to proper	7.28-11

FORM CMS-2587(02-99) Provious Versions Obsolele

Event IO: YCFU21

Facility ID: 923005

If continuation sheet Page 2 of 2

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