PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUILDING	·		,
		345179	B. WING			3/2013
NAME OF PR	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
RRIANCE	NTER HEALTH AND RE	TIREMENT	7	52 E CENTER AVE		
DRIAN CE	MIEK HEALTH AND KE	(TINEWEW)	, n	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 152 SS=D	483.10(a)(3)&(4) RIG REPRESENTATIVE	SHTS EXERCISED BY	F 152	F 152		
	under the laws of a S jurisdiction, the rights exercised by the pers law to act on the res In the case of a resid incompetent by the S surrogate designated	son appointed under State ident's behalf. ent who has not been judged state court, any legal I in accordance with State resident's rights to the		Corrective action cannot be accomplished for the alleg practice in regards to Resident has been disched the resident has been disched. Facility residents who have or other legal surrogates has potential to be affected by alleged deficient practice; the Director of Social Serv	ed deficient dent #2 as arged. e guardians ave the this same therefore,	
	by: Based on interviews facility failed to obtain resident's responsible	e party to administer a new sted for 1 of 3 sampled		complete an audit of current to identify those with guarand/or legal surrogates. A finding will be immediated corrected. This audit will completed on or before 2-1. 3. Measures put into place to	dians ny negative y be 14-13. ensure that	
,	The findings are:		* * * * * * * * * * * * * * * * * * *	the alleged deficient practi not recur include: In-servic facility license nursing stat	ces does ce for	
	12/10/12 with diagno Alzheimer's disease a Minimum Data Set (N specified the resident	and others. The initial MDS) dated 12/17/12 thad short and long term and severely impaired		department managers regar rights of a guardian or lega surrogate, how to identify a or legal surrogate and care the guardian or legal surrog Administrator	rding the Il a guardian requests of	
ABORATOB¥	revealed a hospital H 10/02/12 that specific to iodine and codeine preferred to avoid all	al record was reviewed and istory and Physical dated at the resident was allergic and specified the family pain medicines due to past	=	"Preparation and/ or execution of this p correction does not constitute admission agreement by the provider of the truth of alleged or conclusions set forth in the S Deficiencies. The Plan of Correction is and/ or executed solely because it is rec provisions of Federal and State law."	n or of the facts statement of s prepared quired by	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 the other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosured 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 disclosured to the patients. days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite o continued program participation.

FEB 2 5 2013

if continuation sheet Page

by: SXH 1 of 16

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			LE CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUII B. WIN			ĺ	2
		345179	S. VViii			01/1	8/2013
	OVIDER OR SUPPLIER NTER HEALTH AND RE	TIREMENT		75	EET ADDRESS, CITY, STATE, ZIP CODE 12 E CENTER AVE OORESVILLE, NC 28115		-
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F 152	Treatment" dated 12/resident's responsible facility that she was to medication changes of the document had at the RP that listed her addition, a document Assessment" dated 1 #2's RP did not want without being notified included the RP's nar Further review of Resrevealed a nurses' er 12/25/12 at 3:54 AM physician was notified agitation and Tylenol Medication Administrative 12/25/12 was reviewed a received 2 doses of 1 dated 12/25/12 at 5:0 #2's RP was present #2 was lethargic. The Resident #2 had been specified Resident #2 of the new order for 1 the facility that Reside Tylenol. The RP requisent to the Emergence A "Resident Transfer specified Resident #2 specified Resident #2 specified Resident #2 specified Resident Transfer specified Resident #2	document titled "Consent to 10/12 specified the e party (RP) notified the be contacted before any were made for Resident #2. hand written note made by contact information. In titled "Nursing Admission 2/10/12 specified Resident any new medication given first. The document me and contact information. sident #2's medical record try made by Nurse #1 dated that specified the on-call d for the resident's increased	F	152	and or Director of Nursing, Unit M Coordinator and or Staff Development Coordinator of Morsing, Unit M Coordinator of Physician telephon daily, Monday thru Friday if period of three (3) week and weekly for a period of four thereafter to ensure guardia surrogates are notified of m changes. 4. The Director of Nursing and Administrator will analyze for trends and patterns. The of Nursing and/ or Administrator the finding to a QA/F Committee weekly for a perfour (4) weeks and then mo The QA/PI Committee will the effectiveness of the abound will add additional interbased on negative outcomes identified to ensure continuous compliance. "Preparation and/ or execution of this picorrection does not constitute admission agreement by the provider of the truth of alleged or conclusions set forth in the St Deficiencies. The Plan of Correction is and/ or executed solely because it is required."	fanager/ will e orders for a d then (4) weeks ns or legal edication d/ or the data e Director trator will Pl ciod of nthly. evaluate ve plan rventions ed an of or The facts atement of prepared	
	12/25/12 and diagnos	ultted to the hospital on sed with altered mental urinary tract infection (UTI).	· ·				

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 01/18/2013 345179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 752 F CENTER AVE BRIAN CENTER HEALTH AND RETIREMENT MOORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSG IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 152 F 152 Continued From page 2 The hospital discharge summary dated 12/31/12 specified, "The resident does have an allergy to Tylenol and was apparently given this at the nursing home which made her more confused." On 01/18/13 at 11:15 AM Nurse #2 was interviewed and reported that she was Resident "Preparation and/ or execution of this plan of #2's admitting nurse on 12/10/12. She confirmed correction does not constitute admission or that she completed the "Nursing Admission agreement by the provider of the truth of the facts Assessment" for Resident #2 and was notified by alleged or conclusions set forth in the Statement of the RP that the resident was not to receive any Deficiencies. The Plan of Correction is prepared new medications without being notified first. and/ or executed solely because it is required by provisions of Federal and State law." Nurse #2 stated that Resident #2 was unable to communicate or make her needs known and relied on staff to anticipate her needs. Nurse #2 stated she documented the RP's request to be notified before Resident #2's medications were changed on the admission assessment and notified the oncoming nurse during shift report. Nurse #2 stated she did not document the information anywhere else in the medical record. On 01/18/13 at 12:45 PM the Admissions Receptionist was interviewed and reported she recalled completing the "Consent to Treatment" form with Resident #2's RP. She added that the RP stated she did not want changes made to Resident #2's medications without being notified. The Admissions Receptionist stated she notified the Nurse #2 of the RP's request. On 01/18/13 at 11:05 AM the Director of Nursing (DON) was interviewed and stated she would not have expected Nurse #1 to contact Resident #2's RP at 3:45 AM to notify her of a new order to administer Tylenol to Resident #2. The DON

Facility ID: 922988

added that specific instructions such as family requesting that no new medications be given

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

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER	TIREMENT		7	EET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVE 100RESVILLE, NC 28115		
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F 152	documented in a cersee it. She added at the resident's Medica (MAR) but that it was request was not a ph. On 01/18/13 at 11:50 interviewed and reponew medications and medications the faciliavailable information for a resident and ad Resident #2 the best regarding the resident.	the family should be tral location for all nurses to indeal location would be on ation Administration Record in not required since the ysician's order. AM the Physician was bried that when administering if obtaining orders for new fity had to use the best for making the best decision ded that in the case of available information in twould have come from the cility should have contacted	F	152	"Preparation and/ or execution of this plar does not constitute admission or agreemer provider of the truth of the facts alleged or set forth in the Statement of Deficiencies. Correction is prepared and/ or executed so it is required by provisions of Federal and	nt by the r conclusions The Plan of olely because	
	she contacted the or because Resident #2 stated she received the resident 2 doses Nurse #1 stated she request to be contact to the resident's med would not have know Assessment for the ideas 483.25(a)(3) ADL CADEPENDENT RESIDENT	lephone and reported that III-call physician on 12/25/12 Properties an order for Tylenol and gave of the new medication. If was not aware of the RP's ted before making changes lications. She stated she with to look at the Admission information. If the provided here is a provided to the RP's ted before making changes lications. The stated she with the RPS is a provided here.	F	312	F 312 1. Corrective action has been accomplished for the allege practice in regards to Resic that the Director of Nursing the resident received prope incontinence upon notificat #2 was provided immediate by the Director of Nursing Staff Development Coordinate.	lent #7 in g ensured r tion. NA e training and or the	

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 312	by: Based on observat policy, and staff inte properly provide inc resident observed for	ge 4 IT is not met as evidenced ion, record review, facility erviews facility staff failed to continence care for 1 of 1 or incontinence care, Resident	F	312	regarding the provision of princontinence care. 2. Facility residents who are of for incontinence care have potential to be affected by a alleged deficient practice; the Director of Nursing and Coordinator/ Manager will	lependant the his same herefore, l/ or Unit	
	female patient date: "Separate her labia the other, using ger the fromt to the bac intestinal organisms urethra or vagina. A anus, and use a cle for each stroke by f inward. This metho- contaminated secre Resident #7 was ac with diagnoses that	clied Perineal care of the d 10/06/13 read in part, with one hand and wash with only downward strokes from k of the perineum to prevent serious contaminating the avoid the area around the san section of the washcloth olding each use section d prevents the spread of ations or discharge."	en er enne er		an audit of current residents identify those residents who dependant for incontinence review for any potential par UTI's. The Administrator review the past six (6) mon concerns and Resident Couminutes identifying any issuincontinence care. Any neg finding will be immediately corrected. This audit will be completed on or before 2-1 3. Measures put into place to the alleged deficient practic recur include: In-service for nursing staff by the Director.	s to care and cterns of will ths of ncil ues with ative 4-13. ensure that ce does not or facility or of	
	and cerebral vascu hemiparesis. Review of Resident Data Set (MDS) review memory probledaily decision making Resident #7 as need assistance with actindicated Resident of bowel and bladdent.	lar accident with left #7's Admission Minimum realed she had long and short ems and was impaired for ng. The MDS further assessed iding extensive to total ivities of daily living. The MDS #7 was frequently incontinent			Nursing staff by the Director Nursing and/ or Unit Coord Manager and/ or Staff Deve Coordinator regarding propincontinence care. CNAs walidate understanding with "Preparation and/ or execution of this properties of the truth calleged or conclusions set forth in the S Deficiencies. The Plan of Correction is and/ or executed solely because it is required provisions of Federal and State law."	limator/ elopment er vill return lan of or of the facts tatement of prepared	

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M	ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUI	LDING		(,
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	OVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVE		
BRIAN CE	NTER HEALTH AND RE	TIREMENT		N	OORESVILLE, NC 28115	· · · · · · · · · · · · · · · · · · ·	
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F 312	incontinence care for gathered supplies of wash basin. With Res NA #2 cleaned the gibetween the leg and to back and then turn to clean her buttocks not clean Resident #7 Resident #7, NA #2 carea. Resident #7 ha which was noted in tremoved the soiled bunder her buttocks. If to her back and p NA #2 was asked to not cleaned Residen reached into the was wash cloth that was approximately 3 inch to go toward the resident's peri-area. would have to get more removed her gloves returned to the room proceeded to clean fiving front to back in this area. An interview was core PM with NA #2. NA #2 cleaned Resident #7 #2 further stated she washcloth soiled with washcloth soiled with the soi	ant (NA) #2 providing Resident #7. NA #7 had washcloths, towels and a sident #7 lying on her back roin area (the crease the groin). She cleaned front led the resident on her side and anal area. NA #2 did 7's peri-area. After turning cleaned her buttock and anal id a loose bowel movement, he perineal area. NA #2 rief and put on a clean brief NA #2 then rolled Resident roceeded to fasten the brief. stop at this point as she had t #7's peri-area. NA #2 then h basin and picked up a visibly soiled with feces (spot in diameter) and proceeded dent to clean her peri-area. Topped and asked if she d wash cloth to clean the She stated no, that she ore clean linen. NA #2 and exited the room. NA #2	F	312	demonstration of learning to Director of Nursing, Staff Development Coordinator of Carolina Licensed Nurse (Remote The Director of Nursing, Use Coordinator / Manager and of Development Coordinator of Conduct incontinence care releast three (3) time per weet period of four (4) week, and randomly for a period of the months to validate approprising incontinence care technique being used. Negative finding immediately corrected. 4. The Director of Nursing and Administrator will analyze for trends and patterns. The of Nursing and/ or Administrator the finding to a QA/F Committee weekly for a periour (4) weeks and then mone The QA/PI Committee will the effectiveness of the abound will add additional interpassed on negative outcomes identified to ensure continual compliance. "Preparation and/ or execution of this placement by the provider of the truth of alleged or conclusions set forth in the St. Deficiencies. The Plan of Correction is and/ or executed solely because it is required provisions of Federal and State law."	or a North LN/LPN). nit or Staff will ounds at k for a d then ree (3) ate es are ng will be d/ or the data e Director trator will Pl riod of nthly. evaluate ve plan rventions s ed an of f the facts atement of prepared	

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	OVIDER OR SUPPLIER NTER HEALTH AND R	ETIREMENT		REET ADDRESS, CITY, STATE, ZIP COD	E .		
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F 312	Continued From pa	ge 6	F 312				
	with the Staff Devel The SDC stated that assistants are hired skills by a nurse or before they are allo He stated incontine that should be obse nursing assistants a peri-area during ince stated NA #2 should washcloth to clean An interview was or PM with the Director stated it was her ex thoroughly clean a during incontinence #2 should have use	onducted 01/17/13 at 4:05 PM opment Coordinator (SDC). It when new nursing they are observed performing a senior nursing assistant wed to work independently, noe care was one of the skills erved. The SDC stated that are expected to clean the ontinence care. He further d have used a clean Resident #7's peri-area. Inducted on 01/17/13 at 4:45 or of Nursing (DON). The DON pectation for staff to female resident's peri-area at care. She further stated NA and a clean washoloth when		"Preparation and/ or execution of does not constitute admission or a provider of the truth of the facts a set forth in the Statement of Defic Correction is prepared and/ or exe it is required by provisions of Fed	greement by the lleged or conclusions tiencies. The Plan of cuted solely because		
F 323 SS≠D	HAZARDS/SUPER The facility must er environment remail as is possible; and adequate supervisi prevent accidents.	ACCIDENT	F 323	1. Corrective action ha accomplished for the practice in regards to that upon notification Nursing ensured the place and operational Direction of Nursing training to NA #1resplacement and operal alarms.	e alleged deficient o Resident #1 in n, the Director of alarms were in al. Further, the grovided garding the		
	and staff interviews	tion, medical record review, the facility failed to put a chair lace for 1 of 3 residents		Facility residents wi have the potential to this same alleged de	be affected by		

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPL	E CONSTRUCTION	(X3) DATE SUI	
AND PLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUIL	DING			3
	345179	B. WIN	G	·	í	8/2013
NAME OF PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE 2 E CENTER AVE		
BRIAN CENTER HEALTH AND R	RETIREMENT		M	OORESVILLE, NC 28115		 +
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
with diagnoses which Review of Resident Data Set (MDS) da long and short term impaired for daily diassessed her as new with transfers and higher review of the had a fall prior to act two falls after she with revealed and the plan listed dat 01/10/13 revealed and 10/10/13 revealed she stood up from attempted to sit backed. For revealed a pressure chair and her bed. An Interdisciplinary 01/13/13 revealed and her bed. An Interdisciplinary 01/13/13 revealed and her bed.	falls, Resident #1. ed: dmitted to the facility 01/09/13 on included right hemiparesis. t #1's Admission Minimum ted 01/16/13 revealed she had memory problems and was ecision making. The MDS ending extensive assistance her balance as being unsteady a sitting to standing position. The MDS revealed Resident #1 dmission to the facility and had was admitted to the facility. t #1's care plan for falls dated a pressure pad alarm for her were initiated on 01/10/13. The tes the resident had fallen as	L.	323	therefore, the Director and/ or Unit Coordinator and/ or Staff Developm Coordinator will comple current residents to idea residents with safety all they are in place as dee necessary. Any negative be immediately correct will be completed on or 13. 3. Measures put into place the alleged deficient processing staff by the Dir Nursing staff by the Dir Nursing and/ or Admin regarding the use of saft An IDT team will cond of identified residents to most effective safety all The Director of Nursing Coordinator/ Manager make safety rounds dain thru Friday, for a period weeks, then three (3) the and randomly for a period weeks, to include the use alarms. Any negative if the immediately correct "Preparation and/ or execution of the traileged or conclusions set forth in Deficiencies. The Plan of Correction does not constitute admagreement by the provider of the traileged or conclusions set forth in Deficiencies. The Plan of Correction do'r executed solely because it is not provided to the constitute admagreement by the Plan of Correction do'r executed solely because it is not provided to the constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not constitute admagreement by the Plan of Correction does not con	or/ Manager tent lete an audit of ntify those arms to assure med e finding will ed. This audit r before 2-14- e to ensure that actice does not ce for facility rector of istrator fety alarms. uct a review o ensure the arm is in use. g, Unit and IDT will ly, Monday d of four (4) mes weekly iod of four (4) mes weekly iod of four (4) se of safety indings will ed. his plan of ission or uth of the facts the Statement of on is prepared	

Facility ID: 922988

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345179	B. WING		1	C 8/2013
NAME OF PE	ROVIDER OR SUPPLIER	340110		TREET ADDRESS, CITY, STATE, ZIP CODE		0/10/10
BRIAN CE	NTER HEALTH AND RE	TIREMENT		752 E CENTER AVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	QULD BE	(X5) COMPLETION DATE
F 323	A review of the Resident revealed Repressure pad alarm of the Resident revealed Repressure pad alarm of the Resident revealed Repressure pad alarm of the Resident #1 in wheel chair. Resident on her wheel chair. An observation was in AM of Resident #1 are wheel chair. Resident on her wheel chair. On 01/18/13 at 11:05 made of Nursing Ass Resident #1 from her finishing the transfer Resident #1 did not the Resident #1 did not check bed alarm was in plate An interview was cor AM with NA #1. He is have an alarm on her there was a pad for a bed but the cord from the stated there was #1 also stated, looking Resident #1 should in the An interview was cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a cor AM with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1. Note that the reverse was a core and with Nurse #1.	itent Care Grid used by know how to care for each sident #1 was to have a on her bed. made on 01/17/13 at 12:30 her room sitting in her t #1 did not have an alarm made on 01/18/13 at 10:33 gain sitting in her room in her t #1 did not have an alarm 6 AM an observation was sistant (NA) #1 transferring wheelchair to bed. After NA #1 then left the room. have a bed alarm on her bed. to see if the Resident #1's ce. aducted on 01/18/13 at 11:20 tated Resident #1 did not r wheel chair. He stated an alarm on Resident #1's in the pad was not connected. No alarm box on the bed. NA ang at his Care Grid, that	F 32	4. The Director of Nursin Administrator will and for trends and patterns Director of Nursing and Administrator will rep finding to a QA/PI Coweekly for a period of weeks and then month QA/PI Committee will effectiveness of the abwill add additional into based on negative outcidentified to ensure cocompliance. "Preparation and/or execution of the correction does not constitute admiss agreement by the provider of the trul alleged or conclusions set forth in the Deficiencies. The Plan of Correction and/or executed solely because it is provisions of Federal and State law."	lyze the data . The d/ or ort the minittee four (4) ly. The evaluate the ove pian and erventions comes intinued s plan of sion or h of the facts e Statement of n is prepared required by	

PRINTED: 02/04/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 A. BUILDING Ç B. WING 01/18/2013 345179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 752 E CENTER AVE BRIAN CENTER HEALTH AND RETIREMENT MOORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 Continued From page 9 F 323 been a pad under the resident's cushion in her wheel chair and there should have been a box that the bed alarm was plugged into. An interview was conducted on 01/18/13 at 12:00 PM with the Director of Nursing (DON). She "Preparation and/ or execution of this plan of correction stated it was the Unit Coordinator #1's does not constitute admission or agreement by the responsibility to check to make sure the alarm provider of the truth of the facts alleged or conclusions was implemented. The DON further stated the set forth in the Statement of Deficiencies. The Plan of alarm box and pad should have been on the chair Correction is prepared and/ or executed solely because it is required by provisions of Federal and State law." and the bed. An interview was conducted on 01/18/13 at 12:20 PM with Unit Coordinator (UC) #1. UC #1 stated it was not his responsibility to initiate the alarm. He stated the alarm should have been initiated on 01/10/13 by someone from the interdisciplinary team. He stated nursing assistants and nurses were to check placement. An interview was conducted on 01/18/13 at 12:26 PM with Unit Coordinator #2. She stated it was F 333 everyone's responsibility on the interdisciplinary team to make sure the alarm was put into place. 1. Corrective action has been She further stated, "it was not determined who accomplished for the alleged deficient actually was going to put the alarm on, we just practice in regards to Resident #2 in assumed someone would." She stated the alarm that medical intervention and should have been put on by the nurse who was monitoring were completed as working with her on the 01/10/13. directed by the Attending Physician. F 333 483.25(m)(2) RESIDENTS FREE OF Medication Aide #1 was provided SS=D SIGNIFICANT MED ERRORS

by:

The facility must ensure that residents are free of

This REQUIREMENT is not met as evidenced

any significant medication errors.

with immediate training by the Director of Nursing regarding the

administration of medications.

affected by this same alleged

medications have the potential to be

2. Facility residents who receive

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>	С	
		345179	B. WNG		01/18/2013	
	ROVIDER OR SUPPLIER	ETIREMENT	7	REET ADDRESS, CITY, STATE, ZIP CODE 152 E CENTER AVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLE	ETION
F 333	Based on interviews facility gave the wro sampled residents (IThe findings are: Resident #2 was ad 12/10/12 with diagnoral Alzheimer's disease Minimum Data Set (specified the resident memory impairment cognitive skills for defended and the facility resident and 12/10/13 at 12:0 Coordinator (SDC) with the facility recently transaides to administer reported that the medications by usin Medication Administration and 12/10/14/13 at 12:0 Coordinator (SDC) with the facility recently transaides to administer reported that the medications by usin Medication Administration added that if a reside picture on the MAR could verify a reside arm band. He added aide #1 did not iden on the MAR or her at the medications to Fresident #2 experies	s and record review the ng medications to 1 of 3 Resident #2). mitted to the facility on oses that included and others. The initial MDS) dated 12/17/12 of that short and long term and severely impaired aily decision making. #2's medical record revealed do 1/08/13 that specified the were being closely 'medication error." O PM the Staff Development was interviewed and stated sident #2 was given Resident accident. He stated that the sitioned to using medication residents' medications. He edication aides were trained to	F 333	deficient practice: therefore Director of Nursing and/or Coordinator/ Manager and Development Coordinator complete an audit of current to identify those residents assistance in the administratheir medications. This aurompleted on or before 2- 3. Measures put into place to the alleged deficient pract recur include: In-service licensed nursing staff and aides by the Director of Nor Staff Development Cooregarding the proper ident resident by use of arm bar photograph prior to the add of medications with return demonstration. The Direct Nursing, Unit Coordinator and/or Staff Development Coordinator will conduct Administration Audits at It (3) times weekly for a per days and randomly thereat validate appropriate patient identification techniques a used. Any negative finding immediately corrected. "Preparation and/or execution of this correction does not constitute admissionagement by the provider of the truth alleged or conclusions set forth in the Deficiencies. The Plan of Correction and/or executed solely because it is reprovisions of Federal and State law."	or Unit // or Staff will nt residents who need ation of dit will be 14-13. ensure that ice does not for facility medication ursing and/ ordinator ifications of d and/ or ministration tor of //Manager Medication east three iod of 90 fier to at re being g will be plan of on or of the facts Statement of is prepared	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345179	B. WIN			C 01/18/2013	
	ROVIDER OR SUPPLIER		<u> </u>	75	EET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVE OORESVILLE, NC 28115	1 000	0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 333	physician. On 01/17/13 at 12:15 interviewed and report administering medical trained to verify a rest of residents on the Maresident's arm band be medications. She state entered Resident #8's and the resident was asked Resident #8's aresident was and was beauty shop. Medical to the beauty shop are and asked the beautic Resident #8. Medical the resident in the beintended for Resident became aware a little Resident #8's medical medication aide report had picture identificate confirmed that Resident MAR. On 01/17/13 at 3:45 F (DON) was interviewed identified the medication aide resident was that she stated that Resident # adverse reaction from received in error. The documentation of the Resident #2 that included the resident was that she stated that #2 that included the resident #2 that included the reside	PM medication aide #1 was reed she was new to tions. She stated she was idents' identity using pictures AR or by checking a pefore she administered ated that on 01/18/13 she is room to give medications not there. She stated she murse aide where the is told the resident was in the ation aide #1 added she went aid saw a female resident can if the resident was tion aide #1 stated she gave auty shop the medications if #8. She added she time later that she gave attions to Resident #2. The red that not all residents ion on the MAR and ent #8 did not have a picture. PM the Director of Nursing ed and stated the facility had ion error occurred as result are failed to identify who the gave medications she is DON provided medications given to	F	333	4. The Director of Nursing and Administrator will analyze to for trends and patterns. The of Nursing and/ or Administ report the finding to a QA/P Committee weekly for a per four (4) weeks and then more The QA/PI Committee will the effectiveness of the above and will add additional interbased on negative outcomes identified to ensure continue compliance. "Preparation and/ or execution of this placorrection does not constitute admission agreement by the provider of the truth of alleged or conclusions set forth in the Stand/ or executed solely because it is required provisions of Federal and State law."	the data a Director trator will I iod of othly. evaluate we plan eventions ed an of or the facts atement of prepared	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(****)	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		c
		345179	B. WING		01/18/2013
	OVIDER OR SUPPLIER	TIREMENT	7	EET ADDRESS, CITY, STATE, ZIP CODE 62 E CENTER AVE 10 ORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 333	- Sinemet (anti-Pa - PreserVision (m - Ditropan (blood On 01/18/13 at 11:50 was interviewed and medication error and allergic reaction of fa monitoring of the res that he was concerned receiving Abilify and resident. He stated to experience a significal result of the medication would expect medication determine the identity administering medical have expected the fa	notic) 5mg) 17 grams pressure medication) 20mg arkinsonism) 25/100mg ultivitamin) 1 tablet pressure medication) 5mg OAM Resident #2's physician stated he was notified of the ordered Benadryl for the cial swelling and close ident's vital signs. He stated ad about the resident its potential to harm the the resident did not ant negative outcome as on error. He added he ation aides to properly y of a resident before ations and added he would acility to update picture	F 333	"Preparation and/ or execution of this plan does not constitute admission or agreemen provider of the truth of the facts alleged or set forth in the Statement of Deficiencies. Correction is prepared and/ or executed so it is required by provisions of Federal and	t by the conclusions The Plan of lely because
F 441 SS=D	they transitioned to u 483.65 INFECTION SPREAD, LINENS The facility must esta Infection Control Pro safe, sanitary and co to help prevent the d of disease and infect (a) Infection Control The facility must esta Program under whic (1) Investigates, con in the facility;	Program abilsh an Infection Control	F 441	F 441 1. Corrective action has been accomplished for the allege practice in regards to Resid providing NA #2 with imm training by the Director of regarding the transport of s and disposal of soiled incor supplies. Further, the equip potentially contaminated w under the supervision of the of Nursing.	ent #7 by ediate Nursing oiled linen ntinence oment as cleaned

Facility ID: 922988

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IOENTH IOXISON NO.	A. BUILDING		С
		345179	B. WING		01/18/2013
	ROVIDER OR SUPPLIER ENTER HEALTH AND R	ETIREMENT	7	REET ADDRESS, CITY, STATE, ZIP CODE 52 E CENTER AVE MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 441	(3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident. (2) The facility musi communicable dise from direct contact direct contact will tr (3) The facility musi hands after each di hand washing is ind professional practic (c) Linens Personnel must has	o an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must asse or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 441	 Facility residents who rece assistance with Activities of Living (ADLs) have the pole affected by this same all deficient practice; therefor Director of Nursing and/ of Coordinator/ Manager and Development Coordinator complete an audit of current to identify those residents assistance with incontinent This audit will be complete before 2-14-13. Measures put into place to the alleged deficient practification recur include: In-service fursing staff by the Director Nursing and/ or Staff Deverond and incontinence sup Director of Nursing, Unit 	of Daily otential to leged e, the r Unit / or Staff will nt residents receiving ce care. ed on or ensure that ce does not for facility or of elopment of soiled plies. The
	by: Based on observatinterviews the facilitincontinence brief a	NT is not met as evidenced cion, facility policy, and staff by failed to properly contain an an an towel soiled with feces ons of incontinence care,		Coordinator/ Manager and Development Coordinator conduct care rounds at least times per week for a periodays and randomly thereaf validate appropriate infections.	will st three (3) d of 90 der to
	female patient date	ed: tled Perineal care of the d 10/06/12, read in part: bag. Dispose of solled articles		"Preparation and/ or execution of this parameters and constitute admission agreement by the provider of the truth alleged or conclusions set forth in the State Deficiencies. The Plan of Correction is and/ or executed solely because it is reprovisions of Federal and State law."	n or of the facts Statement of s prepared

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STATEMENT OF DEFICIENCIES		I—————————————————————————————————————) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING					
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		345179	B. VVIIV	· · · ·		01/1	3/2013	
NAME OF PROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CENTER HEALTH AND RETIREMENT				752 E CENTER AVE				
				W	OORESVILLE, NC 28115	1031	0/51	
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TAG			TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
			<u> </u>)			
E 484	Cautianad Fasas add	n 14		441				
F 441	Continued From page 14			F 441				
:	in the appropriate receptacle."							
	An observation of incontinent care was made on 01/17/13 at 2:20 PM. Nursing Assistant #2 performed incontinence care for Resident #7. During incontinence care Resident #7 was noted		oted		techniques are being used. Any negative findings will be immediately			
					corrected.	mmediatery		
					corrected.			
					4. The Director of Nursing and/ or			
to have had a loose bowel m					Administrator will analys			
was soiled and saturated					for trends and patterns. The			
removed the soiled brief and			Director of Nur Administrator v		Director of Nursing and/			
	the resident's wheel chair. NA #2 did no try to contain the contents on the brief. It				Administrator will report			
#7's slippers were sitting in the s					finding to a QA/PI Committee			
	wheelchair as well as the foot rests for the				weekly for a period of fo	ur (4)		
	wheelchair. NA #2 also placed a towel which was				weeks and then monthly. The			
	visibly soiled with stool in the wheelchair seat. NA		İ		QA/PI Committee will e			
	#2 needed to leave the room to obtain more supplies for cleaning the resident. NA #2 picked				effectiveness of the abov			
			,		will add additional interv			
		soiled towel and exited the			based on negative outcor			
	room.				identified to ensure conti	nued		
	An interview was conducted on 01/17/13) F		compliance.			
		2 stated she should have						
made sure she had a trash					"Preparation and/ or execution of this p correction does not constitute admission			
		. She stated she should not			agreement by the provider of the truth o alleged or conclusions set forth in the Si			
			1			tatement of		
	wheelchair.			Deficiencies. The Plan of Correcti and/ or executed solely because it		prepared		
					provisions of Federal and State law."	junou oj		
		nducted 01/17/13 at 4:05 PM			· -			
	with the Staff Development Coordinator (SDC). The SDC stated the expectation was for staff to uses a trash bag for soiled linen and soiled							
	incontinent briefs. He stated the soiled brief							
	should not have been placed in the wheelchair.							
	An interview was conducted on 01/17/13 at 4:45							
	PM with the Director of Nursing (DON). The DC stated it was her expectation for nursing		***					
assistants to use trasi								
	: addigitating (0 nga (14)	on bags to contain somed	1					

Facility ID: 922988

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 345179 01/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVE BRIAN CENTER HEALTH AND RETIREMENT MOORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 441 Continued From page 15 F 441 briefs and linen. "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 conclusions 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."