STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156		7/25/13

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F 156 Notice of Rights, Rules, Services and Charges

Criteria I

Resident #44 was educated on the State Agency contact information regarding complaint reporting on 7/19/13.
The Administrator verified the Facility's posting of State Agency contact information regarding complaint reporting on 7/1/13.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	DON	7/30/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by	F 156	***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. Notification of the State Agency contact information will be provided to current residents and families via mail enclosed with the July financial statement. ***Criteria 3*** The Activities Director will update the Resident Council Meeting Agenda by 7/25/13 to include the review of State Agency contact information regarding complaint reporting. A Resident Council Meeting will be held by 7/25/13 to update current attendees on State Agency contact information regarding complaint reporting. The Administrator, Director of Nursing or Activities Director will randomly audit 5 residents per week for 12 weeks to verify understanding of availability of State Agency contact information regarding complaint reporting, and document these audits on the monitoring tool. Opportunities will be corrected by the Administrator or Activities Director daily as identified during these random audits.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 156	Continued From page 2 such benefits. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to inform and review with residents the state contact information for 1 (Resident # 44) of 3 residents interviewed. During an interview conducted on 6/26/13 at 3:45 PM., Resident #44 stated she went to all of the Resident Council meetings and did not know how to contact the state agency if she had a complaint. She further indicated she did not know where the information was posted in the facility. On 6/26/13 at 5:15 PM, Administrative staff #6 stated she attended all the Resident Council meetings. She indicated the number for the complaint intake unit is given to the residents during the admission process and she did not go over that information during the meetings.	F 156	***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Administrator for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157	***Criteria I*** The Director of Nursing informed the Physician for Resident #54 of the missed doses of IVIG on 6/28/13.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 157	Continued From page 3	F 157		

clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and physician, resident and staff interview, the facility failed to inform the physician that intravenous immunoglobulin (IV IG), Gamunex-C, a replacement therapy for immunoglobulin G deficiency, was not administered as ordered for 1 (Resident #54) of 1 sampled resident with an order for IV IG medication. Findings included:

Resident #54 was admitted to the facility on 12/8/12 and was re-admitted on 5/13/13 with multiple diagnoses including immunoglobulin G (Ig G) deficiency, a condition when the body

Criteria 2
Residents with Physician's Orders to receive outpatient medication administration have the potential to be affected by this alleged deficient practice.
The Director of Nursing, Staff Development Coordinator or Unit Manager will complete an audit of residents with Physician's Orders for outpatient medication administration during the last 30 days to verify scheduling and completion of these outpatient treatments by 7/25/13. As a result of these audits the Director of Nursing, Staff Development Coordinator or Unit Manager will notify the Physician and Responsible Party will be of delays or lack of administration by 7/25/13.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 157	Continued From page 4 doesn't produce enough immunoglobulin (antibodies). The quarterly MDS assessment dated 6/20/13 indicated that Resident #54 was cognitively intact. On 6/25/13 at 7:50 AM, Resident #54 was interviewed. She stated that she had Ig G deficiency and she was supposed to receive IV IG treatment every month. She added that since she was admitted to this facility she had not received the IV IG and that she was worried. Review of the admission orders dated 12/8/12, there was no order for IV IG to be given monthly. On 4/25/13, there was a progress notes from the neurology clinic. Resident #54 was seen by the neurologist that day and the orders included " Gamunex-C (a replacement therapy for Ig G deficiency) 10 gram/100 ml (milliliter) - infuse 35 grams by intravenous route at a rate of 1 mg/kg/min (milligram/kilogram/minute) for 30 minutes, then may increase to 8 mgs/kg/min every 4 weeks with solumedrol (corticosteroid used to reduce allergic reaction) 40 mgs and Benadryl (antihistamine used to treat allergic reactions) 50 mgs pre infusion. The notes indicated that the treatment would start at (name of hospital) on 4/27/13. The MARs (Medication Administration Records) for April, May and June, 2013 were reviewed. Gamunex - C treatment was not transcribed to the MAR. On 4/29/13, there was a physician's order which included "Gamunex C 10% 35 gm (gram) IV	F 157	***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manger will re-educate all Licensed Nurses, including those working PRN and weekends, on the policy and procedure related to Notification of Change including the notification of Physician and Responsible Party regarding Scheduling outpatient treatments by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will review the 24 hour report and carbon copies of Physician's Orders 4 times per week for 12 weeks to verify Physician notification with a change of condition and document these audits on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 157	Continued From page 5 every 4 week via port a cath (a small device installed under the skin to give easy access to the vein); Ig G and subclasses every 3 months; solumedrol 40 mgs IV and Benadryl 50 mgs IV pre infusion. " There was no documentation in the records that Resident #54 had received the IV IG (Gamunex-C) from 4/27/13 to 6/26/13. On 6/26/13 at 10:45 AM, administrative staff #1 was interviewed. She stated that the facility did not receive the order for IV IG treatment until 4/29/13 and the resident was scheduled to receive it at the hospital on 5/7/13. On 5/7/13, Resident #54 went to the hospital for IV IG treatment but her porta cath was not working (would not flush) so the IV IG was not administered. Administrative staff #1 further stated that on 5/9/13, Resident #54 was admitted to the hospital for nausea and vomiting and was re-admitted back to the facility on 5/13/13. Administrative staff #1 further stated that the facility does not administer blood products therefore IV IG was not provided at the facility. She added that she had informed the physician about it but she forgot to document. Administrative staff #1 did not explain why other arrangements were not made for Resident #54 to receive the IV IG treatment after 5/13/13 (re-admission). On 6/27/13 at 1:39 PM, the physician was interviewed. The physician stated that he was not aware that Resident #54 was not receiving the IV IG monthly as ordered. He indicated that the IV IG was ordered by the infectious disease doctor	F 157	***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 157	Continued From page 6 and he expected the facility to administer it. If not, he should have been informed so he could make other plans/arrangements.	F 157		7/25/13
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure that a lint screen in 1 of 3 clothes dryers was cleaned regularly to prevent a fire hazard. The findings included: On 6/27/13 at 6:33 am, a tour of the laundry room was conducted. A housekeeper was present, folding laundry and all three of the dryers had clothes in them. She shared that they have a schedule to clean the clothes dryers every two hours and record the activity on a dryer log. When asked to inspect the lint screens, she opened each door to display them. The first two lint screens were clean with minimum lint on the floor. However, the third dryer had heavy white lint on the screen and white lint on the floor of the dryer. The housekeeper stated that her supervisor monitored the dryer logs to ensure that the screens were cleaned throughout the day. On 6/27/13 at 7:44 am, the administrative staff #3 was interviewed. He brought in the completed	F 253	***Criteria 1*** The Lint screens for each dryer were cleaned immediately following identification on 6/27/13. ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice ***Criteria 3*** The Environmental Services Director will re-educate all Laundry staff on the procedures, frequency and documentation of cleaning the lint screens by 7/25/13. The Environmental Services Director or the Maintenance Director will randomly review the documentaion log and validate accuracy 3 times per week for 12 weeks and document these audits on the	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 253	Continued From page 7 dryer log that he kept in his office and it revealed that the activity for 6/27/13 had already been filled out for the entire day. He stated that his expectation was for his staff to clean the lint screens every two hours and if the screen was last cleaned at 8:00 pm yesterday, it should have still been clean this morning at 6:00 am. The administrative staff returned at 7:55 am, stating that he had in-serviced his staff not to "pre-chart the dryer logs and to clean the screens either after every 2 loads or 2 hours, whichever was lesser. His written guidelines, dated 6/27/13, emphasized that a clogged screen, preventing air from circulating, could create a fire hazard. A follow up interview was conducted with the housekeeper at 6/27/13 at 11:22 am. She shared that she always filled out the log in advance. Yesterday she stated that she cleaned the lint screens and planned to clean them again when she arrived at 6:00 am, but didn't get the chance to complete the task, before they were inspected.	F 253	monitoring tool Opportunities will be corrected by the Environmental Services Director or the Maintenance Director daily as identified during these random audits. ***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Environmental Services Director for 3 months. The committee will evaluate and make further recommendations as indicated.	7/25/13
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278	Date of Compliance: July 25, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 278	Continued From page 8 that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that each section of the MDS assessments were signed by the individual who completed it prior to completion date on 3 (Residents #54, # 123, and #67) of 17 sampled residents. Findings included: 1. Resident # 54 was admitted to the facility on 12/8/12. The quarterly Minimum Data Set (MDS) assessment was signed as compete by the MDS coordinator on 6/20/13. Section Z of the assessment contained only one signature from the MDS coordinator. The sections she completed were A, B, G, H, I, J, L, M, N, O and P. Sections C, D, E, and K were completed but there were no signatures from the staff that completed them.	F 278	***Criteria 1*** Late entry documentation and signatures for staff members completing sections C, D, E and K on the MDS were obtained for residents #54, #123, and #67. ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice ***Criteria 3*** The Regional Care Management Coordinator will re-educate all MDS staff on the accurate completion of sections C, D, E and K of the MDS to include signatures by the Interdisciplinary team member completing each section prior to signature of the MDS Coordinator completing the assessment and subsequent transmittal of the MDS assessment, by 7/25/13.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 278	Continued From page 9 On 6/26/13 at 12:30 PM, MDS coordinator #1 was interviewed. She stated that she was not aware that the staff had to sign their sections before she could sign the assessment as complete. 2. Resident #123 was admitted to the facility on 5/25/13. The admission Minimum Data Set (MDS) assessment was signed as compete by the MDS coordinator on 6/5/13. Section Z of the assessment contained only one signature from the MDS coordinator. The sections she completed were A, B, G, H, I, J, L, M, N, O and P. Sections C, D, E, F, and K were completed but there were no signatures from the staff that completed them. On 6/26/13 at 12:30 PM, MDS coordinator #1 was interviewed. She stated that she was not aware that the staff had to sign their sections before she could sign the assessment as complete. 3. Resident # 67 was admitted to the facility on 1/12/07. The quarterly Minimum Data Set (MDS) assessment was signed as complete by the MDS coordinator on 6/25/13. Section Z of the assessment contained only one signature from the MDS coordinator. The sections she completed were A, B, G, H, I, J, L, M, N, O, and P. Sections C, D, E, K and Q were completed but there were no signatures from the staff that completed them. On 6/26/13 at 12:30 PM, MDS coordinator #1 was interviewed. She stated that she was not aware that the staff had to sign their sections	F 278	The Resident Care Management Director will randomly review 10 completed MDS assessments weekly for 12 weeks to verify accurate completion with signatures prior to transmission and document these audits on the monitoring tool Opportunities will be corrected by the Resident Care Management Director or MDS Coordinator daily as identified during these audits. ***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Resident Care Management Director for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 278	Continued From page 10 before she could sign the assessment as complete.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, physician, family, resident and staff interview, the facility failed to administer the intravenous immunoglobulin (IV IG), Gamunex-C, as ordered for 1 (Resident #54) of 1 sampled resident with an order of IV IG medication. Findings included: Resident #54 was admitted to the facility on 12/8/12 and was re-admitted on 5/13/13 with multiple diagnoses including immunoglobulin G (Ig G) deficiency, a condition when the body doesn't produce enough immunoglobulin (antibodies). The quarterly MDS assessment dated 6/20/13 indicated that Resident #54 was cognitively intact. On 6/25/13 at 7:50 AM, Resident #54 was interviewed. She stated that she had Ig G deficiency and she was supposed to receive IV IG treatment every month. She added that since	F 309	***Criteria 1*** Resident #54 was discharged from the facility on 7/5/13. ***Criteria 2*** Residents with Physician's Orders to receive outpatient medication administration have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Development Coordinator or Unit Manger Will complete an audit of residents with Physician's Orders for outpatient medication administration during the last 30 days to verify scheduling and completion of these outpatient treatments by 7/25/13.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 309	Continued From page 11 she was admitted to this facility she had not received the IV IG treatment and that she was worried. Review of the admission orders dated 12/8/12, there was no order for IV IG to be given monthly. On 4/25/13, there was a progress notes from the neurology clinic. Resident #54 was seen by the neurologist that day and the orders included " Gamunex-C (a replacement therapy for Ig G deficiency) 10 gram/100 ml (milliliter) - infuse 35 grams by intravenous route at a rate of 1 mg/kg/min (milligram/kilogram/minute) for 30 minutes, then may increase to 8 mgs/kg/min every 4 weeks with solumedrol (corticosteroid used to reduce allergic reaction) 4 mgs and Benadryl (antihistamine used to treat allergic reactions) 50 mgs pre infusion. The notes indicated that the treatment would start at (name of hospital) on 4/27/13. On 4/29/13, there was a physician's order which included "Gamunex C 10% 35 gm (gram) IV every 4 week via porta cath (a small device installed under the skin to give easy access to the vein); Ig G and subclasses every 3 months; solumedrol 40 mgs IV and Benadryl 50 mgs IV pre infusion." There was no documentation in the records that Resident #54 had received the IV IG treatment from 4/27/13 to 6/26/13. The MARs (Medication Administration Records) for April, May and June, 2013 were reviewed. Gamunex - C treatment was not transcribed to the MAR.	F 309	***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on the process for scheduling and verifying completion of Physician ordered outpatient medication administration by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will review the 24 hour report and carbon copies of Physician's Orders 4 times per week for 12 weeks to verify scheduling and completion of physician ordered outpatient medication administration, audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 309	Continued From page 12	F 309		

The doctor's progress notes were reviewed. On 5/1/13, the notes revealed that Resident #54 had expressed concern that she had not received the IV IG since admission to the facility. The notes revealed that Resident #54 had missed 4 dosages of IV IG. The notes indicated that the resident was scheduled to receive it on 5/7/13. There were no other notes in the chart after 5/1/13.

On 6/26/13 at 10:45 AM, administrative staff #1 was interviewed. She stated that the facility did not receive the order for IV IG treatment until 4/29/13 and the resident was scheduled to receive it at the hospital on 5/7/13. On 5/7/13, Resident #54 went to the hospital and her porta cath was not working (would not flush) so the IV IG was not administered. Administrative staff #1 further stated that on 5/9/13, Resident #54 was admitted to the hospital for nausea and vomiting and was re-admitted on 5/13/13. Administrative staff #1 further stated that the facility does not administer blood products therefore IV IG was not provided at the facility. Administrative staff #1 did not explain why other arrangements were not made for Resident #54 to receive the IV IG treatment after 5/13/13 (re-admission).

On 6/26/13 at 11:30 AM, interview with Nurse #1 was conducted. After reviewing their appointment book, she stated that there was no scheduled date set up for Resident #54 to have her IV IG treatment at the hospital.

On 6/26/13 at 4:10 PM, a family member was interviewed. She stated that the orders from the neurology clinic, including the order for IV IG, was

Criteria 4

The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:
July 25, 2013.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 309	Continued From page 13 sent to the facility the day of the appointment (4/25/13) and the treatment (IV IG) was scheduled for 4/27/13 at the hospital. The family member did not understand how and why the staff missed the order from the neurology clinic for the IV IG. The family member voiced her concern that Resident #54 had not received her IV IG since she was admitted to the facility in December, 2012. She stated that she had been telling the staff about it but nobody had followed up on it. On 6/27/13 at 1:39 PM, the physician was interviewed. The physician stated that he was not aware that Resident #54 was not receiving the IV IG monthly as ordered. He indicated that the IV IG was ordered by the infectious disease doctor and he expected the facility to administer it, if not he should have been informed so he could make other plans/arrangements.	F 309		
F 325 SS=B	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325	***Criteria I*** A Medication Variance Report was completed on 6/28/13 by the Director of Nursing, including notification of the Physician for the transcription error regarding physician's orders for nutritional supplements for resident #53. The supplement order was transcribed to the Medication Administration Record for resident #53 on 6/28/13.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 325	Continued From page 14	F 325		

Based on record review and staff interview, the facility failed to provide the house supplement as ordered to prevent further weight loss for 1 (Resident #53) of 3 sampled residents triggered for weight loss. Finding includes:

Resident #53 was admitted to the facility on 5/1/13 with multiple diagnoses including Diabetes Mellitus, Hypertension, Depression, Anemia and Vitamin D deficiency.

The admission MDS assessment dated 5/28/13 indicated that Resident #53 was cognitively intact and needed limited assistance with eating. The assessment also indicated that the resident's weight was 131 lbs (pounds).

The care plan for nutrition dated 6/6/13 was reviewed. The problem was potential for weight loss related to poor food/fluid intake. The goal was for the weight to be stabilized with no significant weight change in 90 days. The approaches included to provide diet as ordered, and to provide supplements as ordered.

The weights documented for Resident #53 were:
5/1/13 - 132 lbs
5/30/13 - 122 lbs
6/14/13 - 121 lbs
6/21/13 - 123 lbs

Review of the doctor orders revealed that on 5/23/13, there was an order for house supplement 4 oz (ounces) twice a day with medication pass.

The dietary progress notes dated 5/31/13 was reviewed. The notes indicated that Resident #53's

Criteria 2

Residents with Physician's Orders to receive nutritional supplements have the potential to be affected by this alleged deficient practice.

The Director of Nursing, Staff Development Coordinator or Unit Manager will complete an audit of residents with Physician's Orders for nutritional supplements during the last 30 days to verify accurate transcription to the Medication Administration Record by 7/25/13.

The Director of Nursing, Staff Development Coordinator or Unit Manager will correct discrepancies as identified and Medication Variance Reports will be completed for opportunities identified by 7/25/13.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 325	Continued From page 15 weight was 121.6 lbs, a weight loss of 10.2 lbs/7.7 % since admission/within 30 days. The resident had consumed 50-75% of her meal. The notes further indicated that an order for house supplement 4 oz (ounces) twice a day with medication pass was ordered on 5/23/13 to promote weight stability. Review of the June, 2013 Medication Administration Record (MAR) revealed that the house supplement was transcribed to be given twice a day but the timing was written at 10:00 AM (once a day) only. On 6/27/13 at 10:30 AM, CMA #3 was interviewed. She stated that she was assigned to administer the medications for Resident #53. She stated that she had administered the house supplement to Resident #53 once a day as it was written on the MAR. She was not aware that the order was twice a day. On 6/27/13 at 10:35 AM, administrative staff #1 was interviewed. She stated that the nurse who signed off the MAR at the end of the month was not available for interview. She acknowledged that the house supplement was transcribed incorrectly.	F 325	***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on accurate transcription of physician's orders including nutritional supplements by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit the carbon copies of Physician's Orders and Medication Administration Records 4 times per week for 12 weeks to verify accurate transcription of Physician's orders, these audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or unit Manager daily as identified during these audits	7/25/13
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 329	Continued From page 16 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and physician interview, the facility failed to obtain a TSH (thyroid-stimulating hormone) blood level for one (Resident #233) of ten residents reviewed for unnecessary medications. The findings included: Resident #233 was admitted to the facility 4/24/13. Cumulative diagnoses included hypothyroidism. An Admission Minimum Data Set (MDS) dated 5/1/13 indicated Resident #233 had short and long term memory impairment and was moderately impaired in decision-making. A physician orders dated 4/24/13 revealed an order for Levothyroxine 112 mcg. (micrograms)		***Criteria 4*** The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013. **F 329 Unnecessary medications** ***Criteria I*** A TSH was collected for Resident #233 by 6/28/13 and was within normal limits. ***Criteria 2*** Residents receiving a thyroid replacement hormone have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Development Coordinator or Unit Manager will complete an audit of all residents receiving a thyroid replacement hormone by 7/25/13 to verify a physician's order is in place for TSH monitoring.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 329	Continued From page 17 po (by mouth) daily for hypothyroidism. A review of the physician orders from 4/24/13 through 6/276/13 indicated there were no orders written for Resident #233 to have a TSH level drawn. A review of the hospital records revealed no TSH level. Medication Regime Reviews by the consultant pharmacist dated 5/21/13 and 6/17/ 13 indicated no recommendations for a TSH level. During an interview on 6/27/13 at 2:30 PM, the physician stated he saw Resident #233 in May and June 2013 and would have looked in the medical record and hospital records to see if a TSH level had been completed. He also stated he usually received a pharmacy consultant recommendation if lab work is needed for a resident. He was not aware that a base TSH level had not been completed for Resident #233.	F 329	***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on requirements for laboratory monitoring via TSH for those residents receiving a thyroid replacement hormone by July 25, 2013. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit the carbon copies of Physician's Orders 4 times per week for 12 weeks to verify lab (TSH) monitoring is in place for residents receiving thyroid replacement hormones, these audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits.	7/25/13
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was 5% or less as evidenced by 3 errors of 25 opportunities resulting to a 12% error rate. Findings included:	F 332		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 332	Continued From page 18 1. Resident #258 was admitted to the facility on 6/13/13 with multiple diagnoses including iron deficiency anemia. The June, 2013 physician's orders indicated that Resident #258 had an order for Ferrous Sulfate 325 mgs (milligrams) 1 tablet by mouth three times a day with meals for iron deficiency anemia. On 6/25/13 at 5:46 PM, Certified Medication Aide (CMA) #1 was observed during the medication pass. CMA #1 was observed to prepare and to administer the medications for Resident #258 including the Ferrous Sulfate. The dinner tray had not been delivered yet to the resident. On 6/25/13 at 6:00 PM, CMA #1 was interviewed. She stated that the dinner cart was always delivered on the hall between 6:00 - 6:15 PM. She added that she should have waited for the dinner tray before administering the Ferrous Sulfate. 2. Resident # 251 was admitted to the facility 6/14/13. The June 2013 physician's orders indicated that Resident # 251 had an order for potassium chloride 20 meq. (milliequivallents) one tablet three times daily. Take with food or milkshake. On 6/25/13 at 5:23PM., CMA #3 was observed during the medication pass. She was observed to prepare and to administer the medications for Resident #251 including the potassium chloride. Neither food nor a milkshake was given to the	F 332	***Criteria 4*** The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 332	Continued From page 19 resident with the medication. On 6/25/13 at 5:37 PM., CMA #3 stated the evening meal would arrive at 6:00PM. She stated she knew the potassium chloride should be given with food or a milkshake and she just forgot it. On 6/26/13 at 10:10 AM., Administrative staff #1 stated she expected all medications to be administered per physician's order and the potassium chloride should have been given with food or a milkshake. 3. Resident #21 was admitted to the facility on 2/8/13. Cumulative diagnoses included a cerebrovascular accident (CVA). Resident #21 had a gastrostomy feeding tube and received all medications via the gastrostomy tube. On 6/25/13 at 5:59 PM., Nurse #2 was observed during medication pass. Nurse #2 prepared the medications and administered the medications via the feeding tube. She gave the medications in approximately 90 ml. (milliliters) of water and did not give a water flush between the medications. On 6/25/13 at 5:59 PM., Nurse #2 stated the policy was to flush the gastrostomy tube before and after medications had been administered. On 6/26/13 at 10:10 AM., Administrative staff #1 stated she expected the nursing staff to administer the medications per the facility gastrostomy tube policy which stated to flush with 5--10 ml. of water between medications.	F 332		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 356 SS=C	Continued From page 20	F 356		7/25/13

INFORMATION

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview, the facility failed to post daily staffing with accurate information for 4 out of 4 days.

Criteria 1

The Director of Nursing updated the Daily Facility Staffing Posting by documenting the RN and LPN hours separately by 6/28/13.

Criteria 2

All residents have potential to be affected by this practice.

Criteria 3

The Administrator and Director of Nursing were re-educated regarding the daily staffing posting requirements by the Division Director of Education on 6/27/13. The Administrator or Director of Nursing will audit the daily staffing posting daily for 1 week, then weekly for 11 weeks to ensure posting is timely and accurate. Opportunities will be corrected by the Administrator or Director of Nursing daily as identified

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 356	Continued From page 21 The findings included: On 6/24/13 at 11:20 am, during the initial tour, the daily staffing was noted to list all licensed nurses together, at each shift and did not recognize the actual hours worked for the licensed practical and registered nurses. On 6/25/13 at 9:05 am, the daily staffing was noted to list all licensed nurses together, at each shift and did not recognize the actual hours worked for the licensed practical and registered nurses. On 6/25/13 at 3:11 pm, the daily staffing was noted to list all licensed nurses together, at each shift and did not recognize the actual hours worked for the licensed practical and registered nurses. On 6/27/13 at 6:25 am, the Administrative Staff #5 was approached about the daily staff posting. He stated that he had three staff that were trained on to fill out the form and that he wasn't aware that it was done incorrectly. He shared that he would make sure that the form was fixed. At 10:38 am, the revised daily staff posting was observed on the bulletin board, however it did not separate the actual hours worked between the licensed practical and registered nurses.	F 356	***Criteria 4*** The results of these audits will be reported to the monthly QAPI meeting by the Administrator and the committee will make recommendations for further action as needed. Date of Compliance: July 25, 2013.	
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	***Criteria 1*** The Fryer and the Meal Tray Carts were cleaned by the Dietary Manager on 6/28/13. ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice related to the Fryer and the Meal Tray Carts.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 371	Continued From page 22 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to maintain a deep fryer free from greasy buildup and to maintain 1 of 2 open rack meal carts free from debris between scheduled cleanings. The findings included: 1. Review of the Daily Cleaning Schedule revealed that the Fryer/Floor/Wall was to be cleaned once a week by #4 Cook. The description stated "drain grease from fryer, use cleaner to thoroughly clean inside and outside of fryer, clean wall and floor around fryer." The schedule indicated this was to be done on Tuesdays. The column for the initials of the person who completed the task was left blank. On 6/24/13 at 11 AM the deep fryer was observed to have dark brown liquid (oil) in it with a build up of dark brown debris (approximately 1 - 2 inches in height) around all 4 sides of the interior of the deep fryer (1 - 2 inches above the level of the liquid). The outside of the deep fryer was observed to have greasy brown buildup on areas of the front and the one visible side panel. On 6/26/13 at 12:20 PM the deep fryer was observed to have dark brown liquid (oil) in it with a build up of dark brown debris (approximately 1 - 2 inches in height) around all 4 sides of the	F 371	***Criteria 3*** The Dietary Manager will re-educate all Dietary staff on the procedures, frequency and documentation of cleaning the Fryer and the Meal tray carts by 7/25/13. The education regarding the procedure for cleaning the Fryer includes the following details. The Fryer will be drained, deep cleaned using oven cleaner and rinsed once per week. After drying, fresh oil will be added to the Fryer. The Fryer baskets will be cleaned daily following use. The education regarding procedures for cleaning the Meal Tray Carts includes the following details. The Meal Tray Carts will be cleaned with Sanitizer and Stainless Steel Cleaner to removes spills and debris daily following use. The Meal Tray Carts will be deep cleaned 3 times per week using hot, soapy water and a scrub brush followed by Sanitizer and Stainless Steel Cleaner The Dietary Manager will randomly review the documentation log and visually validate cleaning of the fryer and the meal tray carts 3 times per week for 12 weeks and document these audits on the monitoring tool	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 371	Continued From page 23	F 371		

interior of the deep fryer (1 - 2 inches above the level of the liquid). The outside of the deep fryer was observed to have greasy brown buildup on areas of the front and the one visible side panel. Observations of the tray line at this time revealed that fried chicken had been prepared for lunch.

On 6/27/13 at 11:15 AM the deep fryer was observed to have dark brown liquid (oil) in it with a build up of dark brown debris (approximately 1 - 2 inches in height) around all 4 sides of the interior of the deep fryer (1 - 2 inches above the level of the liquid). The outside of the deep fryer was observed to have greasy brown buildup on areas of the front and the one visible side panel.

On 6/27/13 at 11:20 AM., interview with the Dietary Manager revealed that the fryer was to be cleaned weekly and that when staff completed the task they were to initial it off as completed. She added that at the end of the day she was to review that cleaning tasks had been completed but that she had not done it this week.

On 6/27/12 at 11:25 AM., interview with Administrative Staff #7 revealed that she believed staff were adhering to the cleaning schedule and just failed to document that the fryer had been cleaned. She indicated that she was not aware that the debris on the fryer continued to look as it had on 6/24/13.

2. Review of the daily cleaning schedule revealed the food carts were to be cleaned on Monday by Aide #3 and Friday by Aide #6. The description stated "spray carts with cleaner, spray carts down thoroughly, wipe spills or stains." The column for the initials of the person

Opportunities will be corrected by the Dietary Manager daily as identified during these audits.

Criteria 4

The results of the audits will be reported in the monthly Quality Assurance Performance Improvement meeting by the Dietary Manager for 3 months. The committee will evaluate and make further recommendations as indicated.

Date of Compliance:

July 25, 2013.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 371	Continued From page 24 who completed the task was filled in with initials for Monday. The Friday cleaning was not yet due. On 6:26 at 12:15 PM 1 of 2 open rack meal carts used to take meal trays to the dinning room was observed to have a build-up of yellowish beige colored debris on the vertical bars that staff grasp onto when pushing the food cart prior to and after delivering meal trays to residents. On 6/27/13 at 11:13 AM 1 of 2 open rack meal carts used to take meal trays to the dinning room was observed to have a build-up of yellowish beige colored debris on the vertical bars that staff grasp onto when pushing the food cart prior to and after delivering meal trays to residents. On 6/27/13 at 11:27 PM interview with Administrative Staff #7 revealed that she acknowledged there was debris on the open rack meal cart. She indicated that this had been a problem she was aware of and that improvements had been made in keeping the meal carts clean.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	***Criteria I*** The Director of Nursing completed Medication Variance Forms and notified the Physician of missed doses of Ambien ER on 5/20/13, 5/21/13 and 5/23/13 and for missed doses of Vimpat on 5/29/13, 5/30/13 and 5/31/13 for Resident #54 on 6/28/13. The Charge Nurse obtained Ambien ER on 5/24/13 and Vimpat on 6/1/13 for resident #54.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 425	Continued From page 25 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff, family and resident interview, the facility failed to ensure that medications were requested, received and administered as ordered as evidenced by missed dosages of medications due to unavailability for 1 (Resident # 54) of 10 sampled residents. Findings include: Resident #54 was admitted to the facility on 12/8/12 and was re-admitted on 5/13/13 with multiple diagnoses including seizure disorder and insomnia. The quarterly MDS assessment dated 6/20/13 indicated that Resident #54 was cognitively intact. Review of the physician's orders on admission (5/13/13) revealed that Resident #54 was on Ambien ER (a sedative/helps with sleep) 12.5 mgs (milligrams) 1 tablet by mouth at bedtime for insomnia and Vimpat (anti seizure drug) 50 mgs - 4 tablets by mouth twice a day for seizures. The MARs (Medication Administration Records) for May, 2013 were reviewed. The MAR revealed	F 425	***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Developmernt Coordinator or Unit Manager will conduct an audit of all medications storage rooms, refrigerators and medications carts to verify medications currently ordered are available for administration. The audit will be completed by 7/25/13. ***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on the policy and procedure for ordering and receiving medications by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit all medication rooms and medication carts weekly for 12 weeks to verify medication currently ordered are available for administration, these audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 425	Continued From page 26 that ambien was not administered to Resident #54 on 5/20/13, 5/21/13 and 5/23/13. The notes at the back of the MAR indicated that ambien was not administered due to being out of supply and was waiting for the pharmacy to deliver. The MARs for May, 2013 revealed that vimpat was not administered for 5 doses, on 5/29/13 at 9:00 PM dose, 5/30/13 and 5/31/13 at 9:00 AM and 9:00 PM doses. The notes at the back of the MAR indicated that vimpat was not administered due to being out of supply. Review of the nurse's notes revealed that Resident #54 had seizure activity on 6/4/13 at 12:45 AM (unwitnessed) and on 6/6/13 at 5:00 PM (witnessed). On 6/26/13 at 4:10 PM, a family member was interviewed. The family member indicated that there were days that the facility was out of medications (ambien and vimpat) and therefore Resident #54 did not receive them for days. The family member was worried having to miss several doses of the seizure medication might have caused the resident to have seizure activity. The family member also stated that Resident #54 had missed several doses of her sleeping pill. On 6/27/13 at 8:05 AM, CMA #2 was interviewed. She stated that when a resident was out of medication she informed the nurse, and the nurse was supposed to check the pyxis, if not available, the nurse would call the pharmacy. She added that she normally faxed the sticker for refill to the pharmacy when 8 tablets/capsules were left on the punch card.	F 425	***Criteria 4*** The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 425	Continued From page 27 On 6/27/13 at 8:15 AM, Nurse #1 was interviewed. She could not remember if she was informed by the CMA when the ambien and vimpat ran out. She stated that when a resident ran out of medication, she checked the pyxis, and if not available she had to call the pharmacy. She further stated that after hours, the pharmacy had an emergency number that she could call. After hours, the pharmacy could call the back up pharmacy to deliver the medication. On 6/27/13 at 9:15 AM, Resident #54 was interviewed. She stated that she had not received some of her medications (ambient and vimpat) because the facility had ran out of supply. She indicated that she needed the ambien because she could not sleep at night and the vimpat for the seizures. She stated that she had 2 episodes of seizure activity this month of June. On 6/27/13 at 2:20 PM, administrative staff #1 was interviewed. She stated that she believed that the staff had faxed or scanned the sticker for refill to the pharmacy timely. She stated that the pharmacy did not send the medications because they (ambien and vimpat) were controlled medications and they needed a script. There was a delay in the delivery of the medications because the pharmacy had to wait for the script from the doctor. She indicated that from now on she would make sure that she had emergency supply of medications in the pyxis at all times.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428	***Criteria I*** A TSH was collected for Resident #233 by 6/28/13 and was within normal limits.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 428	Continued From page 28 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and consultant pharmacist interview, the consultant pharmacist failed to report the missing laboratory monitoring of TSH (thyroid stimulating hormone) blood level for one (Resident # 233) of ten residents reviewed for unnecessary medications. The findings included: Resident #233 was admitted to the facility 4/24/13. Cumulative diagnoses included hypothyroidism. An Admission Minimum Data Set (MDS) dated 5/1/13 indicated Resident #233 had short and long term memory impairment and was moderately impaired in decision-making. A review of physician orders dated 4/24/13 revealed an order for Levothyroxine 112 mcg. (micrograms) po (by mouth) daily for hypothyroidism. A review of the medical record revealed no physician orders to obtain a TSH level; hospital discharge records did not indicate a TSH level; laboratory test results were reviewed with no TSH	F 428	***Criteria 2*** Residents receiving a thyroid replacement hormone have the potential to be affected by this alleged deficient practice. The Director of Nursing, Staff Development Coordinator or Unit Manager will completed an audit of all residents receiving a thyroid replacement hormone by 7/25/13 to verify a physician's order is in place for TSH monitoring. ***Criteria 3*** The Director of Pharmacy Services, the Director of Nursing or Staff Development Coordinator will educate the Consultant Pharmacist to request baseline labs for monitoring residents on thyroid replacement hormones during the first review following admission to the facility by 7/25/13. The Director	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 428	Continued From page 29 level noted; Medication Regime Reviews by the consultant pharmacist dated 5/21/13 and 6/17/ 13 indicated no recommendations. Hypothyroidism was noted as a diagnosis on the medication regime review. On 6/27/13 at 11:30 AM, the pharmacy consultant stated if a resident received levothyroxine and had a TSH level noted in the medical record, he would recommend the level be checked annually or more often if problems were noted. When informed that there was not a base TSH level on Resident #233's medical record since the admission date of 6/24/13 and that the Medication Regime Reviews dated 5/21/13 and 6/17/13 had not indicated that a TSH level be obtained, he stated he waited three months from admission to see if the physician ordered a TSH level, then would make a recommendation in July for a TSH level.	F 428	of Pharmacy services will review the pharmacy consultant report monthly for 3 months to verify residents receiving thyroid replacement hormones have been reviewed and verify a request for baseline lab monitoring has been completed. This review will be documented and provided to the facility via monthly report. This report will be reviewed by the Director of Nursing monthly and opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager as identified during these reviews.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	***Criteria 4*** The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 30 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications in 2 (lower 300 hall and upper 200 hall medication carts) of 6 medications carts and 1 of 2 medication room refrigerators (100/300 hall). The findings included: The facility's policy on " Insulin Storage Recommendations " dated 4/10/13 was reviewed. The policy indicated that opened vial of Humalog was good for 28 days at room temperature. 1. On 6/27/13 at 10:55 AM, the medication carts were observed. On the lower 300 hall medication cart, there were 2 opened vials of Humalog that	F 431	***Criteria 1*** The expired medications were discarded and replaced immediately following identification. ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. An audit of all medications storage rooms, refrigerators and medications carts and all expired or opened and unlabeled items identified were discarded immediately. The audit will be completed by 7/25/13. ***Criteria 3*** The Director of Nursing, Staff Development Coordinator or Unit Manager will re-educate all Licensed Nurses, including those working PRN and weekends, on the policy and procedure for labeling and storing medications by 7/25/13. The Director of Nursing, Staff Development Coordinator or Unit Manager will audit all medication rooms and medication carts weekly for	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 31 were expired. The open dates written on the vials were 5/17/13 and 5/19/13. At 11: 20 AM, CMA (certified medication aide) #2 was interviewed. She stated that nurses were supposed to be checking the expiration dates of insulin and the medications in the medication carts daily. At 4:40 PM, Nurse #1 was interviewed. She stated that nurses were supposed to be checking the expiration dates of the medications including insulin daily but these 2 vials of Humalog might have been missed. 2. On 6/27/13 at 11:15 AM, the medication cart on the upper 200 hall was observed. There was a bottle of acid reducer tablets with an expiration date of 5/13. At 11:20 AM, CMA #2 was interviewed. She stated that nurses were supposed to be checking the expiration dates of insulin and the medications in the medication carts daily. At 4:40 PM, Nurse #1 was interviewed. She stated that nurses were supposed to be checking the expiration dates of the medications including insulin daily but this bottle of acid reducer might have been missed. 3. On 6/26/13 at 4:30 PM., an observation of the 100/300 hall refrigerator revealed seven(7) phenergan suppositories (a medication used for nausea) with an expiration date of 4/13. On 6/26/13 at 4:35 PM., Administrative staff #1 stated that she checked the medication room refrigerators every morning for expired medications and did not know how the suppositories had been missed.	F 431	12 weeks to verify medication storage per policy, these audits will be documented on the monitoring tool. Opportunities will be corrected by the Director of Nursing, Staff Development Coordinator or Unit Manager daily as identified during these audits. ***Criteria 4*** The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Director of Nursing for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		7/25/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	260 BISHOP LANE CONCORD, NC 28025

(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 456	Continued From page 32 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family and staff interviews, the facility failed to make repairs, over an extended period of time, on a non-working whirlpool tub, post a sign on a non-working appliance (clothes dryer), in order to prevent a fire hazard and to use a toaster in a safe manner. The findings included: 1.] On 6/27/13 at 9:25 am, Administrative Staff #2 was interviewed about any equipment needing repairs in the facility. He mentioned that the facility had one whirlpool tub that needed repairs. He shared that he had requested new parts to repair the seal on the door but encountered problems since the tub was old and the parts had been discontinued. He stated that the tub has needed this repair since prior to his employment, which began in 2009. For now, he explained that the residents do not use the tub; they only have access to the shower in the bathroom. A.] On 6/26/13 at 4:10 pm, the Responsible Party for Resident 54 stated that she was concerned that the tub on the 300 hall has not been working for a long time. She stated that Resident #54 preffered to have a tub bath and was not comfortable taking a shower.	F 456	***Criteria I*** .The toaster and clothes dryer were repaired by 6/28/13. The facility has obtained approval for replacement of the whirlpool tub and the order has been placed . ***Criteria 2*** All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director or Administrator will complete an audit of essential equipment currently housed in the facility to verify the equipment is in working order, if not it is posted as "Out of Service", and verify repairs are in process, by 7/25/13.	7/30/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 456	Continued From page 33 B.] On 6/27/13 at 9:55 am, Resident #38 stated that she would prefer to take two tub baths a week, but the option was not available. C.] On 6/27/13 at 10:10 am, Resident #54 stated that due to her joint disease, it's easier for her to take a tub bath, but the option was not available. D.] On 6/27/13 at 10:40 am, Resident #23 stated that she always took tub baths at home, because she was always afraid that she would fall in the shower. Administrative Staff # 4 was interviewed on 6/27/13 at 10:45 am. She stated that the whirlpool tub hasn't worked in about five years and that the residents take showers. 2. On 6/27/13 at 6:30 am, a tour was conducted of the laundry room. The housekeeper was present and was folding towels while one of the three dryers was in operation. Upon closer examination it was noted that all three dryers had clothes in them. The housekeeper stated that all of their equipment was working and there were no signs observed on the dryers to indicate, any malfunctions. On 6/27/13 at 9:20 am, Administrative Staff #2 was interviewed about any equipment needing repairs in the facility. He stated that the middle dryer (#2) was out of order and it had been out for a couple of days. At 10:35 am, he indicated that a technician came to fix the dryer, which had a damaged capacitor, which affected the drum working properly and that could create a fire hazard.	F 456	***Criteria 3*** The Dietary Manager will re-educate all Cooks on the safe use of the toaster by 7/25/13. The Administrator, Maintenance Director or Staff Development Coordinator will re-educate all staff on the process for reporting equipment in need of repair and labeling of inoperable equipment as "Out of Service" while awaiting repair by 7/25/13. The Maintenance Director or Administrator will ensure installation of whirlpool tub following delivery. The Maintenance Director or Administrator will randomly monitor essential equipment weekly for 12 weeks to verify equipment is in working order, posted as "out of Service" if awaiting repair and repairs in progress, these audits will be documented on the monitoring tool	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 456	Continued From page 34 He shared that he had disabled the dryer from the electrical panel, to "lock it out" but did not hang a sign to say that it was out of order. The Administrative Staff #2 stated that he told Administrative Staff # 3 of his actions and expected him to inform his housekeeping staff. The housekeeper was re-interviewed on 6/27/13 at 11:25 am. She stated that the dryer #2 had been working last Friday, (June 21), then it went down, but the staff was able to use it yesterday. She indicated that she did not know that it was out of order. Their protocol was if equipment malfunctioned, the staff reported this to their supervisor or Administrative Staff #2. A sign would be hung saying "Out of Commission" on the equipment. She wasn't sure who placed clothes in dryer #2, since the laundry room stayed unlocked during the night, so that third shift staff could access the equipment to launder clothes. On 6/27/13 at 12:00 pm, Administrative Staff #3 provided documentation to demonstrate that he in-serviced his housekeeping staff about their policies and procedures. 3. On 6/27/13 at 3:00 PM during observation of the kitchen the conveyor toaster was observed. The toaster had a rack attached that was used to feed the bread into the conveyor of the toaster. This conveyor then passed the bread through the heating elements to toast the bread. The heating elements were in close proximity to the junction between the rack and conveyor. On the left side of the rack there was a wadded up napkin placed under the rack near the junction of the rack and conveyor belt. The napkin had brown markings on it that appeared to be singe or burn marks.	F 456	***Criteria 4*** The results of the audits will be reported monthly in the Quality Assurance Performance Improvement meeting by the Maintenance Director for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 25, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	06/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 456	Continued From page 35 On 6/27/13 at 3:10 interview with the Administrative Staff #5 revealed he had not previously been unaware of the placement of the napkin on the toaster but he indicated that it should not have been placed there and could be a hazard. The napkin was then removed . On 6/27/13 at 3:15 PM interview with the Administrative Staff #7 revealed that she had not previously been aware of the placement of the napkin on the toaster. She then questioned the Dietary Manager (DM) who stated that the napkin had been placed under the corner of the toaster rack purposely in order to raise the height of the rack so the bread would feed into the toaster properly. The DM added that the old napkin was removed and replaced with a new one every morning. On 6/27/13 at 3:17 PM the Administrative Staff #5 and #7 acknowledged that the napkin should not have been placed on the toaster as it was a hazard. They also stated that the problem should have been reported to maintenance and that maintenance would need to modify the toaster rack with a non flammable material such as metal.	F 456		

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

RECEIVED
AUG 12 2013
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING 01 - MAIN BUILDING B. WING	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K 045 Correction for the alleged deficient practice noted as "egress illumination, exit discharge from day room would leave area in darkness," was to connect one of the room's two light fixtures unswitched to emergency power to provide uninterrupted lighting in the room. The Maintenance Director will survey the remainder of the building to determine proper emergency lighting in all like areas and if need, correct upon discovery. All findings and corrections will be reported to and discussed during the next three monthly Safety Committee meetings with continued review quarterly thereafter until next annual survey. Correction date 8/6/2013	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: egress illumination, exit discharge from Day room would leave the area in darkness. 42 CFR 483.70(a)	K 045		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A,	K 067	K067 Correction for the alleged deficient practice noted as "all dampers in return vents throughout facility have excess lint build up on dampers," was to check and clean all return vent dampers in facility. The Maintenance Director will continue monitoring dampers with spot checks during monthly air conditioner p.m. and filter changes and check and clean all as needed quarterly. All findings will be reported to an discussed during monthly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/8/2013

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.

CW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 067	Continued From page 1 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: all damper in return vents through out facility have excess lent build up on dampers. 42 CFR 483.70(a)	K 067	K067 (cont) Safety committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date 8/30/2013 K076 Correction for the alleged deficient practice noted as "oxygen cylinders were not in a secure rack at storage area for empty and full cylinders," was an inservice made available for all staff regarding proper storage of oxygen cylinders in secure racks.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: oxygen cylinders were not in a secure	K 076	The Maintenance Director will do spot checks during daily rounds to insure future compliance and report all findings at the monthly Safety Committee meetings for the next three months and continue with quarterly reports until next annual survey. Completion date of 8/30/2013	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 076	Continued From page 2 rack at storage area for empty and full cylinders. 42 CFR 483.70(a)	K 076	K147 Correction for the alleged deficient practice noted as "overhead lights in rooms 206,	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: overhead bed lights in rooms 206, 211 and 314 had objects stored on top of light fixture. 42 CFR 483.70(a)	K 147	211, and 314 had objects stored on top of light fixture," was immediate removal of the objects in those specified rooms. The Maintenance Director will survey the remainder of the building to locate any other like instances and correct upon discovery. An inservice will be offered to all staff regarding storage and decorative objects located on top of light fixtures with an explanation of hazards associated with same. All results and findings will be reported to and discussed during monthly Safety Committee meetings for the next three months and continue with quarterly reviews until next annual survey. Completion date of 8/30/2012	