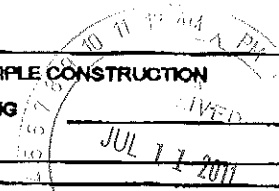


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/11  
FORM APPRO  
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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) COMPLETE DATE
F 272 SS=B	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p>	F 272	<p>F272</p> <ol style="list-style-type: none"> <li>Corrective action has been accomplished for the alleged deficient practice in regards to timely comprehensive assessments related to Resident #154 and #160 by completion of the comprehensive assessments by the MDS Coordinator on June 15, 2011.</li> <li>Facility residents having the potential to be affected by the same alleged deficient practice were identified through review of the MDS roster report, validation transmission reports and a chart audit of comprehensive assessments completed since May 1, 2011, by the Interdisciplinary Team including the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and MDS Coordinator and completed for transmission.</li> </ol> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p>	7-1-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shonda Wingate* TITLE: *Administrator* (X6) DATE: *6-22-11*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 06/16/11  
FORM APPRO  
OMB NO. 0938-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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) COMPLETE DATE
F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to complete an admission minimum data set (MDS) assessment for 2 of 5 sampled residents (Resident #154 and Resident #160).</p> <p>The findings are:</p> <p>1. Resident #154 was admitted on 5/23/11 with diagnosis including Diabetes Mellitus Type II, chronic pain syndrome and a history of falls. Review of the Cognition Assessment completed by the Social Worker on 5/30/11 revealed the resident has moderate cognitive impairment.</p> <p>Review of Resident #154's medical record revealed a Comprehensive Assessment was not present on the chart.</p> <p>Interview with the MDS Coordinator on 6/9/11 at 1:00 PM revealed that given Resident #154 was admitted on 5/23/11, her Assessment Reference Date (ARD - the date that is the end of the look back period) would have been 5/30/11 and 6/5/11 would have been the 14th day, or the day on which the Comprehensive Admission MDS assessment was due to be signed and completed. The MDS Coordinator indicated that the data to complete all sections of the MDS had been gathered during the look back period but the data had not yet been entered into the MDS data base and was overdue. He further indicated that as a result of the MDS not being completed according to the required schedule, the Care</p>	F 272	<p>3. Measures put into place to ensure that the alleged deficient practice does not recur <i>include re-education for members of the Interdisciplinary team, regarding MDS assessment completion requirements by the DON and the Region Care Management Coordinator. An audit of the MDS due roster will be provided by the Nursing Home Administrator (NHA), and reviewed and compared to the MDS calendar daily for comprehensive assessments due, also provided by the NHA for a period of 4 weeks by the IDT including the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and MDS Coordinator to assure timely completion of comprehensive assessments as well as care area assessments. Any identified discrepancies will be documented on the MDS due calendar and the assessment will be completed by the DON, ADON, or MDS nurse/coordinator upon identification.</i></p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p>	

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

PRINTED: 06/18/11  
FORM APPROV  
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 272	<p>Continued From page 2 Area Assessments had also not yet been written.</p> <p>During the interview, the MDS Coordinator indicated that the facility usually has two MDS Coordinators but the other position has been vacant since 5/9/11 and the new MDS Coordinator is not available until 7/5/11.</p> <p>Interview with the Regional MDS Coordinator on 6/9/11 at 1:15 PM revealed that an action plan was put in place to ensure accurate and timely completion of MDS assessments and that MDS assessments were within the regulatory window. The Regional MDS Coordinator stated that she or staff from another facility had been coming to this facility 2 - 3 days a week to help complete the MDS Assessments.</p> <p>Review of the (name of facility) MDS Action Plan dated 6/3/11 revealed, in part: " Description of Issue: Lack of timely MDS assessments. " " Action Items: Audit of new admissions for the last 30 days (May through current), Identify MDS assessments that are out of compliance - schedule most out of date MDS assessments for completion by the IDT (Interdisciplinary team) - schedule MDS assistance from (3 other facilities listed). " The completion date for these items was 6/10/11.</p> <p>Interview with the MDS Coordinator on 6/9/11 at 11:38 indicated that there were 4 new admit residents currently in the facility who's Comprehensive Admission MDS assessments were not completed within the 14 day compliance period for new Admission MDS assessments. Two of these residents were sampled residents. The MDS Coordinator stated that there were no</p>	F 272	<p><i>This comparison will be made during the Monday - Friday morning meeting to include:</i> <i>Social Services, Rehab Manager, MDS Nurse/Coordinator, DON, Dietary Manager and Activities Director.</i></p> <p>4. Data obtained during audits will be analyzed for patterns/trends and reporting in Quality Assessment and Assurance (QA&amp;A) meeting, weekly for a period of 4 weeks, monthly for a period of 3 months and then randomly thereafter. The QA&amp;A Committee will evaluate the effectiveness of the plan and will adjust the plan, as needed based on trends identified to ensure continued compliance.</p> <p>5. Date of Compliance: July 1, 2011</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p>	

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

FORM 04  
PRINTED: 06/16  
FORM APPROV  
OMB NO. 0938-1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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) COMPLETE DATE
F 272	<p>Continued From page 3</p> <p>Significant Change MDS assessments that were overdue; Annual and Quarterly MDS assessments were not discussed.</p> <p>2. Resident #160 was admitted on 5/25/11. Review of the Cognition Assessment completed by the Social Worker on 5/30/11 revealed the resident has severe cognitive impairment.</p> <p>Review of Resident #160's medical record revealed a Comprehensive Assessment was not present on the chart.</p> <p>Interview with the MDS Coordinator on 6/8/11 at 1:00 PM revealed that given Resident #160 was admitted on 5/25/11, her Assessment Reference Date (ARD - the date that is the end of the look back period) would have been 6/2/11 and 6/7/11 would have been the 14th day, or the day on which the Comprehensive Admission MDS assessment was due to be signed and completed. The MDS Coordinator indicated that the data to complete all sections of the MDS had been gathered during the look back period but the data had not yet been entered into the MDS data base and was overdue. He further indicated that as a result of the MDS not being completed according to the required schedule, the Care Area Assessments had also not yet been written.</p> <p>During the interview, the MDS Coordinator indicated that the facility usually has two MDS Coordinators but the other position has been vacant since 5/9/11 and the new MDS Coordinator is not available until 7/5/11.</p> <p>Interview with the Regional MDS Coordinator on</p>	F 272		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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) COMPLETE DATE
F 272	<p>Continued From page 4</p> <p>6/9/11 at 1:15 PM revealed that an action plan was put in place to ensure accurate and timely completion of MDS assessments and that MDS assessments were within the regulatory window. The Regional MDS Coordinator stated that she or staff from another facility had been coming to this facility 2 - 3 days a week to help complete the MDS Assessments.</p> <p>Review of the (name of facility) MDS Action Plan dated 6/3/11 revealed, in part: " Description of Issue: Lack of timely MDS assessments. " " Action Items: Audit of new admissions for the last 30 days (May through current), Identify MDS assessments that are out of compliance - schedule most out of date MDS assessments for completion by the IDT (interdisciplinary team) - schedule MDS assistance from (3 other facilities listed). " The completion date for these items was 6/10/11.</p> <p>Interview with the MDS Coordinator on 6/9/11 at 11:38 indicated that there were 4 new admit residents currently in the facility who's Comprehensive Admission MDS assessments were not completed within the 14 day compliance period for new Admission MDS assessments. Two of these residents were sample residents. The MDS Coordinator stated that there were no Significant Change MDS assessments that were overdue; Annual and Quarterly MDS assessments were not discussed.</p>	F 272		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal</p>	F 312		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 312	<p>Continued From page 5 and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide proper Incontinence care to 1 (Resident #29) of 3 sampled residents. The finding includes:</p> <p>The facility's policy on Perineal Care (undated) was reviewed. The Perineal care policy for the female patient read in part " Ask the patient to bend her knees slightly and to spread her legs. Separate her labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum to prevent intestinal organism from contaminating the urethra or vagina. Avoid the area around the anus and use a clean section of wash cloth for each stroke by folding each section inward. This prevents the spread of contaminated secretions or discharge. Using a clean washcloth, rinse thoroughly from front to back because soap residue can cause skin irritation. Pat the area dry with a bath towel because moisture can also cause skin irritation and discomfort. Apply ordered ointments or creams. Turn the patient on her side to Sim's position, if possible to expose the anal area. Clean, rinse and dry the anal area, starting at the posterior vaginal opening and wiping from front to back " .</p> <p>Resident # 29 was originally admitted to the facility on 08/10/09 with multiple diagnoses including Osteoarthritis, Aortic Aneurism, Diabetes Mellitus, Anxiety, Hypertension,</p>	F 312	<p>F312</p> <ol style="list-style-type: none"> <li>1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #29 regarding inappropriate incontinent care by providing one to one return demonstration training with the identified caregiver by DON on June 8, 2011</li> <li>2. Incontinent residents receiving incontinent care have the potential to be affected by the same deficient practice. Incontinent residents have been identified using the most recent MDS assessment. Resident Care Specialist and Licensed Nurses will be re-educated on proper incontinent care technique with return demonstration by the Staff Development Coordinator, DON and ADON by July 1, 2011.</li> </ol> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p>	7-1-1

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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F 312	<p>Continued From page 6</p> <p>Alzheimer's disease, Gastro esophageal Reflux Disease (GERD) and Depression. The Minimum Data Set (MDS) assessment dated 05/07/11 (assessment reference date) indicated that Resident #29 was cognitively impaired and needed extensive assist with hygiene/grooming.</p> <p>The care plan dated 06/08/11 was reviewed. One of the approaches to the care plan was " to provide incontinent care after each incontinent episode or per established toileting plan " .</p> <p>On 06/07/11 at 4:00 PM, Resident #29 was checked by NA #1 (nursing assistant) for incontinent episode. Resident #29 was observed to be soiled with urine and stool. NA #1 was observed to provide the incontinent care. She brought in two washcloths and one bath towel to be used during the incontinent care. She prepared a wash basin with water and soap at bedside. NA #2 came to help NA #1. Na #1 started by cleaning the front part of the perineum and the inner thigh using the washcloth. The washcloth was observed to have stool in it. She discarded the washcloth and continued cleaning the front area with another washcloth. The second washcloth was again observed to have stool in it. NA #1 was not observed to separate the labia to clean it. NA #2 turned the resident to her side. NA #1 proceeded to clean the anal area using the second washcloth. NA #1 was observed to use the same washcloth to remove the stool and to clean the anal area. After cleaning the area, she used the bath towel to pat the area dry. NA #1 was observed to dry the area between the thighs using the towel. NA #1 was observed to fold the towel several times to wipe the area between the resident's thighs. The</p>	F 312	<p>3. Measures put into place to ensure that the alleged deficient practice does not recur include random peri-care audits to be performed by the Staff Development Nurse, DON, ADON and Unit Managers. 10 random incontinent care audits will be conducted weekly for a period of 4 weeks, then monthly. 4 audits will be conducted on first shift. 4 audits will be conducted on second shift and 2 audits on third shift weekly. Residents will be chosen according to the last MDS assessment and rotated so that all residents are observed. Proof of audits will be documented on the Male/Female Skills Check Off List. Incontinent care education has been included in the orientation of new licensed staff.</p> <p>4. The DON and ADON will review data obtained during incontinent care observations, analyzing to identify patterns and trends, and reporting in monthly Quality Assessment and Assurance Committee meeting weekly for a period of 4 weeks, and then monthly. The above plan will be adjusted as needed to ensure continued compliance.</p> <p>5. Date of compliance: July 1, 2011</p> <p>"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law."</p>	

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

PRINTED: 08/16/  
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OMB NO. 0938-1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/09/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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) COMPLETE DATE
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F 312	<p>Continued From page 7</p> <p>towel was observed to have a yellowish color every time she wiped the area.</p> <p>On 08/07/11 at 4:19 PM, NA #2 was interviewed. NA #2 explained how to do proper incontinence care to a female resident. She emphasized the importance of separating the labia and cleaning the inside from front to back until the washcloth looks clean. She acknowledged that NA #1 did not follow the proper procedure for incontinence care by not separating the labia. She also acknowledged that the resident was not properly cleaned due to the bath towel used to dry the resident has yellowish color every time she wiped it to the area between the resident's thighs.</p> <p>On 08/07/11 at 4:22 PM, NA #1 was interviewed. She acknowledged that she did not separate the labia but she tried to clean the perineum from the back. She also acknowledged that she has to use only two washcloths because they ran out at times. She agreed that the resident was not thoroughly cleaned because the bath towel used to dry the resident's skin was yellowish in color every time she dried the area between the thighs.</p>	F 312		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNPs AND NPs	PROVIDER # 345011	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/9/2011
NAME OF PROVIDER OR SUPPLIER <b>BRIAN CENTER NURSING CARE/LEXI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>279 BRIAN CENTER DRIVE LEXINGTON, NC</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 280	<p><b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to update a care plan for 1 of 15 sampled residents (Resident #94).</p> <p>The findings included:</p> <p>Resident #94 was admitted to the facility on 2/9/11. The hospital discharge summary dated 2/9/11 revealed that the resident had fallen at the assisted living facility where she resided and she sustained a wrist fracture.</p> <p>The admission Minimum Data Set (MDS) dated 2/16/11 indicated that Resident #94's goal was to be discharged to the community.</p> <p>Resident #94's care plan for discharge, dated 3/4/11, revealed a goal of progressing towards or reaching milestones required for discharge in the next 90 days. Approaches included a home evaluation prior to discharge.</p> <p>Physical Therapy notes dated 4/14/11 - 4/20/11 revealed that Resident #94 had a home visit scheduled for 4/21/11 with a physical therapist and a family member. Physical Therapy notes dated 4/21/11 - 4/27/11 revealed that the resident cancelled the home visit because she had decided to remain at the facility for long term care.</p> <p>Social Progress Notes dated 5/5/11 indicated that Resident #94 and her family decided on permanent placement at the facility.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

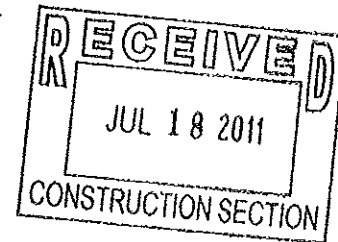
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNF, AND NF:	PROVIDER # <b>345011</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>6/9/2011</b>
NAME OF PROVIDER OR SUPPLIER <b>BRIAN CENTER NURSING CARE/LEXI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>279 BRIAN CENTER DRIVE LEXINGTON, NC</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 280	<p>Continued From Page 1</p> <p>Resident #94's quarterly MDS dated 5/8/11 indicated there was no active discharge plan in place for the resident to return to the community and no determination had been made regarding discharge to the community.</p> <p>Resident #94's care plan for discharge included a statement dated 5/12/11 to continue plan of care and did not reflect the resident's decision to permanently reside at the facility.</p> <p>During an interview on 6/9/11 at 8:45 AM, the Social Worker (SW) acknowledged that Resident #94's care plan did not reflect the resident's current plan to live at the facility. The SW indicated that she herself did not update care plans; rather she discussed residents with the MDS nurses who in turn updated the care plans.</p> <p>During an interview on 6/9/11 at 9:30 AM, the MDS nurse indicated that he was not aware that Resident #94 had decided to permanently reside at the facility. The MDS nurse added that care plans could be updated by other staff members, not just MDS nurses.</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/01/2011
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NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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(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 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, on July 1, 2011 at approximately 1:00pm, there are corroded sprinklers underneath canopy - located behind staff breakroom.	K 062	K062 Correction for the item noted as "corroded sprinklers underneath canopy-located behind staff breakroom": will be cleaning of the sprinklers affected so that temperature sensing element will be clean and readily visible as to temperature color and reliability. The Maintenance director will survey the remainder of the canopies and clean any additional sprinklers upon discovery with any negative findings reported to the Administrator immediately. The Maintenance Director will continue weekly observations of sprinklers for the next three months with monthly inspections continuing thereafter.	7-28-11
K 147 SS=F	42 CFR 483.70(a) 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: Based on observation, on July 1, 2011 at approximately 8:00am onward, the electrical system is noncompliant due to the following:  1. unsecured emergency receptacle - corridor wall between room 202, and unit coordinator office.  2. loss of normal power to automatic transfer switch number one did not cause activation of the generator power indicator, located on the annunciator panel, with transfer switch in emergency mode.	K 147	All results will be reported to and discussed at monthly Safety committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date of July 28, 2011.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shonola Wingate* TITLE: *Administrator* (X6) DATE: *7-14-11*

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JTK

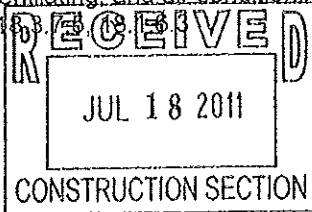
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  07/01/2011
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
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K 147	Continued From page 1 42 CFR 483.70(a)	K 147	<p>K147 Correction for the item noted as (1)"unsecured emergency receptacle between room 202 and Unit manager office" was to immediately tighten and secure as needed. Maintenance director will survey the remainder of the building to determine any like instances and repair upon discovery. Maintenance director will continue weekly checks during normal rounds ongoing. Any negative findings will be reported to the Administrator immediately and all findings will be reported to and discussed during monthly Safety Committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date of July 1, 2011.</p> <p>(2) Correction for item noted as "transfer switch number one did not cause activation of generator power indicator": was to immediately contact generator contractor to inspect system and determine all lighting functioning properly. All systems functioned properly and additional label was added to existing panels to clarify proper lighting. The Maintenance Director will observe proper function of all lighting during weekly generator testing and report to Administrator. All findings to the monthly Safety Committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date of July 8, 2011.</p>	7-28-11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE / BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.4 	K 025	Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by provisions of state and federal law.  K 025 No residents were adversely affected by the alleged deficient practice.  All residents residing within the facility have the potential to be affected by the alleged deficient practice. All smoke walls within the facility attic area were inspected to identify if there were any other PVC pipes penetrating the smoke wall and not equipped with a UL rated fire stop assembly.  Any pipe that penetrates the smoke wall not having UL rated fire stop assembly will have the assembly installed by our Maintenance Director.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water	K 056	The Maintenance Director will inspect /audit the fire walls monthly X 3 months to ensure that all PVC pipes penetrating the smoke walls are equipped with the fire stop assemblies. This audit will be brought to the monthly QA meeting for 3 months.	08/05/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa R Burkhardt ADMINISTRATOR TITLE: \_\_\_\_\_ (X6) DATE: 7-15-11

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NAME OF PROVIDER OR SUPPLIER  UNIVERSAL HEALTH CARE / BRUNSWICK			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422	
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K 056	Continued From page 1 supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.  This STANDARD is not met as evidenced by: Based on observation on Thursday 6/30/2011 between 9:30 AM and 1:00 PM the following was noted: 1) Throughout the facility the sprinkler escutcheon around the sprinkler heads were not set into the ceiling to seal off all openings between it and the ceiling. 42 CFR 483.70	K 056	K 056 No residents were adversely affected by the alleged deficient practice.  All residents have the potential to be affected by the alleged deficient practice. All sprinkler escutcheon plates around the sprinkler heads were inspected to be sure they were sealed to the ceiling. All that were found to not be sealed were repaired to ensure there were no openings between it and the ceiling.  The Maintenance Director will inspect all sprinkler heads on a monthly basis throughout the building to ensure that there are no openings between the ceiling and the escutcheon plate. If any repairs need to be made, the Maintenance Director will complete at that time.	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1  This STANDARD is not met as evidenced by: Based on observation on Thursday 6/30/2011 between 9:30 AM and 1:00 PM the following was noted: 1) The two sprinkler riser systems are equipped with accelerators that have gate valves between it and the riser that are not equipped with an electronically supervised tamper alarm. 42 CFR 483.70	K 061	The results of the Maintenance Director's inspection will be brought to the monthly QA meeting for 3 months.	08/05/11

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K 061  
No residents were adversely affected by the alleged deficient practice.

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

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

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

08/05/11

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July 14, 2011

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

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

Dear Mr. Waddell,

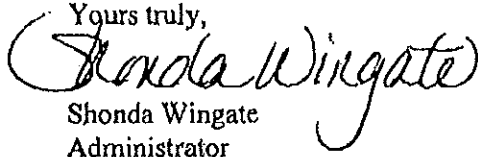
On July 1, 2011, surveyor from NC Department of Health and Human Services Division of Health Service Regulation Construction Section completed an inspection at Brian Center Nursing Care/Lexington. As a result of the inspection, the surveyor alleged that the Facility was not in substantial compliance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

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

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

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

Yours truly,

  
Shonda Wingate  
Administrator



W

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shonda Wingate* TITLE *Administrator* (X6) DATE *7-14-11*

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JFL