SEP 1 8 2013

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

PRINTED: 09/09/2013 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345262	B. WING			1	C 29/2013	
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	20/2010	
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BRIAN CE	NTER HEALTH & REHA	B/HE		HERTFORD, NC 27944				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 281 SS=D	PROFESSIONAL ST.  The services provide must meet profession  This REQUIREMENT by: Based on record rev facility failed to follow failing to give eye dro resident's record revimedications. (Resident #13 was ad 3/14/05 with diagnos Diabetes.  Review of the Quarte (MDS) Assessment or resident as having G Care Area Assessment 2/3/12 identified Vis Resident #13 having Retinopathy.  Review of the Ophtha 3/20/13 documented solution (eye drops) of Glaucoma.  Review of the Physic documented an orde Solution to be given Glaucoma.  Review of the Medica for March 2013 through Resident #13 received Resident Res	d or arranged by the facility hal standards of quality.  I is not met as evidenced liew and staff interviews, the a physician's order by the ps as ordered for 1 of 5 ewed for unnecessary int #13)  I imitted to the facility on the estimated 6/4/13 identified the laucoma. Review of the laucoma and Diabetic lieu as triggering related to Glaucoma and Diabetic lieu come and Diabetic lain obstace of the given in both eyes lien's orders dated 3/20/13 or for Xalatan Ophthalmic in both eyes nightly for lation Administration Records ligh August 2013 showed that lied Xalatan .005% eye drops		281	"Preparation an/or excutation of this correction does not constitute admis agreement by the provider of the truffacts alleged or conclusions set forth statement of defencies. The plan of correction is prepared and/or excute because it is required by the provision federal and state law."  F-281  1. The physician's order dated 3/20 resident #13 prescribes Xalatan Opthalmic Solution to be given in the nightly for treatment of Glaucoma and Diabetic Retinopathy. The order is properly transcribed on the MAR to given  2. All residents receiving eye drops been reviewed for correct transcription.  3. September monthly physician's updates have been compared with current September MARs for accutranscription of current orders. This review process will continue ongoined.  4. Outside consults or appointment which have occurred over the last were reviewed to assure any recontationshave been noted and followed.  5. Consults/Reports will be set asing the order, then filling in the chart. Of that day to be reviewed during rounds. (continued)	sion or h of the in the d solely ons of of oth eyes and now in o be shave tion order the ate s MAR ng. is 60 days nmended. It in a ox* for ding orders	(XA) DATE	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	ιE		TITLE		(X6) DATE	
2 2010110111	0	roundlang, LN			Administrator	9/19	8/13	

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 deficiencles are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 943003

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		345262	B. WNG			08/	29/2013	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
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F 281	to the right eye only.  During an interview v on 8/28/13 at 9:50AM Physicians ' orders s  During an interview v 8/29/13 at 2:15PM he	vith the Director of Nursing  I she stated that all should be followed.  vith the Administrator on e stated that he would expect	F2	281	Clinical rounds include the direct compositive on the physician's order and the ITAR, Dietary Communication or other of assuring the physician's order has be fully and and accurately transcribed an implemented.  The DON will track and trend these day report findings to QAPI for further internal appropriate and will continue for at 190 days with QAPI determining the new further corrective action.	MAR, method een d ily and ventions least		
F 309 SS=D	Each resident must r provide the necessar or maintain the higher mental, and psychos	ARE/SERVICES FOR NG eceive and the facility must y care and services to attain est practicable physical,	F	309	The Director of Nursing is ultimately re ible for this corrective action which will fully implemented by Septermber 25, 2  F-309  1. The physician has been notified and taken regarding resident 104#s skin co.  2. Nurses have been in-serviced regar notification of Resident Change of Corrective actions.	be 2013. I action ondition.		
	by: Based on record rev facility failed to repor one of four residents (resident #104).  Resident #104 was a 5/23/13 and dischard diagnoses including. Hypertension, Arthrit Review of the Minim Assessment dated 5 #104 as moderately	Alzheimer ' s disease, is and Hypothyroidism.			3. Twenty four hour reports for the last have been audited for changes in cond and the clinical record reviewed to det if notification has been made. Follow uthese findings will include notification a education of individual nurses as need 4. A daily review of physicians orders is completed during clinical rounds.  5. These will include a record review to ate that a note has been written regard notification of appropriate parties. Any to notify will be included on the physician order review daily follow up list and no DON's tracking and trending.  6. Results will be reviewed by the Plan Correction PIP Team with recommend made for any additional follow up actice.	dition ermine p with and re- led.  s o valid- ding failure ian's ted in		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	identified Resident #1 pressure ulcers relate incontinence and nut Interventions initiated included turning and weekly skin checks.  Review of the Nursing dated 5/23/13 docum condition as " warm. other skin conditions  Review of the Nursing dated 5/25/13, docum the resident.  Review of the Nursing documented the nurs s room by a visitor to blisters to the left oute notified. Further revie at 3:00AM the physic ordered Zovirax 200n times a day) for 10 da responsible party was The resident was disc with all medications.  Review of the facility was reviewed. The c that the nurse working Saturday, 5/25/13 had to report a change in  During an interview w Specialist #1 (RCS) of worked with Resident	Plan of Care, dated 5/23/13 i04 as having a potential for ed to her immobility, ritional impairment. To prevent pressure ulcers repositioning frequently and g Admission Assessment, ented Resident #104 skin " The resident had no on admission. g Daily Skilled Summary, mented no skin conditions for g Notes, dated 5/26/13 e was called to the resident ' observe a " cluster of er arm." The physician was ew documented on 5/27/13 ian returned the call and ing (milligrams) QID (four ays. The resident ' s is notified of the new order. charged home on 5/27/13	F	309	7. Nurses have been in-serviced regard requirement to notify pysician as well a clarification on what constitutes "chang condition" and how to convey such info by using the SBAR tool.  The Director of Nursing is ultimately resible for sustaining this corrective action will be fully implemented by 9/25/13.	s e in mation spon-		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ B. WING 345262 08/29/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD **BRIAN CENTER HEALTH & REHAB/HE** HERTFORD, NC 27944 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 3 F 309 elbow area and notified the nurse at 7:30AM. During an interview with the Director of Nursing she stated that the facility had done an investigation into the incident involving the blisters after a family member contacted the facility and in conclusion it was determined through staff interviews that the nurse working with Resident #104 on 5/25/13 was made aware from RCS #1 of the blisters on 5/25/13 and this nurse admitted she did not notify the physician of a change in condition. The DON stated that this nurse is no longer working at the facility. Attempts were made to contact this nurse by telephone unsuccessfully. The DON stated that it is expected that all changes in condition be reported to the physician. F 314 F-314 483,25(c) TREATMENT/SVCS TO F 314 PREVENT/HEAL PRESSURE SORES SS=D 1. All residents with Braden Scores indicative of moderate risk (14 and below) have had full Based on the comprehensive assessment of a skin assessments to assure no areas of resident, the facility must ensure that a resident concern go unrecognizable. who enters the facility without pressure sores does not develop pressure sores unless the 2. All residents who have known pressure or non-pressure have been reassessed for individual's clinical condition demonstrates that correct staging and appropriate treatment they were unavoidable; and a resident having modality by the Treatment Nurse. Each pressure sores receives necessary treatment and resident with a wound has been reassessed services to promote healing, prevent infection and for proper interventions including treatment, prevent new sores from developing. surface and positioning, nutritional intervention and potential contributing factors. This audit has been provided to the physician for review

by:

This REQUIREMENT is not met as evidenced

Based on record review, observation and staff

interview the facility failed to accurately assess a

resident's skin integrity on admission and failed to

notify the physician and provide treatment for a

resident with a stage 2 pressure ulcer for 1

and recommendations.

3. The DON will ensure that all TARs are

completing the treatment, re-educating the

in a comprehensive manner including

nurse who missed the treatment and discipline as needed, (continue...)

reviewed each day for potential missed treat-

ments. Any missed treatments will be handled

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F 314  Continued From page 4 (Resident #103) of 3 residents reviewed for pressure ulcers. Findings include:  Resident #103 was admitted to the facility on 8/22/13 with diagnoses of Dementia.  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  4. An updated weekly wound report detailing each wound by stage, whether admitted with or facility acquired and the treatment being completed with any changes will be provided to the DON, the Administrator, the Medical Director and the Regional Clinical Director on a weekly basis for 90 days.  S. The DON will track the incidence of any missed treatments and reported to QAPI for 90 days.  Review of Resident #103's nursing admission	OLIVILIY	O LOIT MITERION IN EX	MILDIO/ ND OLIVAIOLO				CIVID NO	. 0000-000
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHAB/HE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 314  Continued From page 4 (Resident #103) of 3 residents reviewed for pressure ulcers.  Findings include:  Resident #103 was admitted to the facility on 8/22/13 with diagnoses of Dementia.  Review of Resident #103's nursing admission  STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944  PROVIDER'S PLAN OF CORRECTION (KS) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  4. An updated weekly wound report detailing each wound by stage, whether admitted with or facility acquired and the treatment being completed with any changes will be provided to the DON, the Administrator, the Medical Director and the Regional Clinical Director on a weekly basis for 90 days.  F. The DON will track the incidence of any missed treatments and reported to QAPI for 90 days.  The PONIS Witnest Newsons III for the content of the provided to the poly and the reported to QAPI for 90 days.  The PONIS Witnest Newsons III for the content of the provided to the poly and the provided to QAPI for 90 days.								
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F 314  Continued From page 4 (Resident #103) of 3 residents reviewed for pressure ulcers. Findings include:  Resident #103 was admitted to the facility on 8/22/13 with diagnoses of Dementia.  F 314  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  4. An updated weekly wound report detailing each wound by stage, whether admitted with or facility acquired and the treatment being completed with any changes will be provided to the DON, the Administrator, the Medical Director and the Regional Clinical Director on a weekly basis for 90 days.  S. The DON will track the incidence of any missed treatments and reported to QAPI for 90 days.  Review of Resident #103's nursing admission			B/HE		13	00 DON JUAN ROAD		
Continued From page 4  (Resident #103) of 3 residents reviewed for pressure ulcers.  Findings include:  Resident #103 was admitted to the facility on 8/22/13 with diagnoses of Dementia.  Findings include:  Review of Resident #103's nursing admission  Findings include:  Findings	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
assessment dated 8/22/13 revealed she was assessed with a 3 centimeter (cm) blister to her left buttocks and identified as having a stage 1 pressure uicer. Resident #103 was assessed with risk factors of impaired mobility and decreased functional ability.  Review of the skin treatment book revealed no orders for treatment for Resident #103 's 3 cm purple blister on her left buttocks.  Review of the interim plan of care revealed on 8/22/13 Resident #103 had an actual 3 cm blister to her left buttocks and interventions were to notify the physician of changes in the wound or emerging wounds and to turn and reposition frequently to decrease pressure.  During an observation on 8/27/13 at 10:23 AM Resident #103 was observed without a bandage to her left buttocks. Resident #103 was observed with a 3 cm length and ½ inch wide dried open area to her left lower hip.  During an interview on 8/27/13 at 10:24 AM the treatment nurse stated a 3 cm purple blister would mean the resident had a stage 2 pressure ulcer. The treatment nurse stated staff should have put a cover on it and notified the physician.	F 314	(Resident #103) of 3 pressure ulcers.  Findings include:  Resident #103 was as 8/22/13 with diagnose.  Review of Resident # assessment dated 8/3 assessed with a 3 celleft buttocks and iden pressure ulcer. Resident risk factors of im decreased functional.  Review of the skin treorders for treatment for purple blister on her left buttocks an notify the physician of emerging wounds and frequently to decrease.  During an observation Resident #103 was of the left buttocks. Find a 3 cm length an area to her left lower.  During an interview of treatment nurse state would mean the residulcer. The treatment	dmitted to the facility on es of Dementia.  2103's nursing admission 22/13 revealed she was ntimeter (cm) blister to her diffied as having a stage 1 dent #103 was assessed paired mobility and ability.  22 tatment book revealed no for Resident #103 's 3 cm eft buttocks.  23 plan of care revealed on 13 had an actual 3 cm blister and interventions were to f changes in the wound or d to turn and reposition e pressure.  23 n on 8/27/13 at 10:23 AM beserved without a bandage Resident #103 was observed at ¼ inch wide dried open hip.  24 n 8/27/13 at 10:24 AM the da a 3 cm purple blister lent had a stage 2 pressure nurse stated staff should	F3	314	each wound by stage, whether admitt or facility acquired and the treatment I completed with any changes will be pto the DON, the Administrator, the Me Director and the Regional Clinical Director and the Regional Clinical Director aweekly basis for 90 days.  5. The DON will track the incidence of missed treatments and reported to QA 90 days.  The DON is ultimately responsible for taining compliance with this corrective	ed with being rovided dical ector on any API for sus-	

Event ID: CWL811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
10:22 am she stated shon admission. She stated Resident #103 with a bit pressure ulcer. On the was checked as a pression checked as a stage 1 pishe should have checked stage 2. The physician to obtain and initiate a to 483.25(I) DRUG REGIN UNNECESSARY DRUG Each resident's drug reunnecessary drugs. And drug when used in exceeduplicate therapy); or for without adequate moniting indications for its use; or adverse consequences should be reduced or dicombinations of the read Based on a comprehen resident, the facility must who have not used antigiven these drugs unless therapy is necessary to as diagnosed and docu record; and residents with drugs receive gradual disphavioral interventions.	the the DON on 8/29/13 at the did assess the resident sted she assessed dister and it was a stage 2 and admission assessment it issure ulcer and was pressure ulcer. She stated sted the assessment as a should have been notified streatment order.  MEN IS FREE FROM GS  agimen must be free from an unnecessary drug is any essive dose (including per excessive duration; or toring; or without adequate for in the presence of the which indicate the dose discontinued; or any assons above.  The stream of a stream of the stream of the presence of the stream of the stre	F3		conse conse. een  ons ins in, copying recom- onse il in cor will e cover il ipon umed ackage Any d for  clan's o the nents pencies DON, ilrector	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 329	by: Based on record rev review and staff inter discontinue a medical consultant had identifiexcessive duration at to be discontinued for #22) reviewed for unital Resident #22 was ad diagnoses of CHF (con Hypertension and Discontinued for Findings include: Review of the pharm 10/23/12 revealed the Vitamin C be discontinued taking the medication physician agreed and written on 10/31/12. Review of the pharm 1/29/13 revealed the Vitamin C be discontinued taking the medication physician's response the recommendation on 2/12/13. Review of the pharm 3/12/13 revealed he Vitamin C be discontinued taking the medication physician's response the recommendation on 2/12/13 revealed he Vitamin C be discontinued taking the medication physician's response	iew, pharmacy consultant review the facility failed to attend the pharmacy fied as being used for an and the physician had ordered in 10f 5 residents (Resident necessary medications.  Imitted on 7/3/2017 with congestive heart failure), abetes Mellitus.  acy consultation report dated in pharmacist recommended in the checked to implement as acy consultation report dated pharmacist recommended in the since 8/15/12. The district of the resident in since 8/15/12. The was checked as accepting and to implement as written acy consultation report dated pharmacist recommended in the since 8/15/12. The was checked as accepting and to implement as written acy consultation report dated pharmacist recommended in the since due to the resident of the resid	F	329	he may have identified. Any such find be addressed both by the completing process correctly as well as identifying root cause of the process failure.  5. Compliance with timely response we tracked and trended for reporting to Question 120 days at which time the Committed determine appropriate follow up action any patterns identified.  The Administrator is ultimately responsion for sustaining compliance with this conformation which will be fully implemented 9/25/13.	the g the fill be API for e will h based asible	

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F 329	Continued From page	÷7	F;	329				
	5/10/13 revealed he p Vitamin C be disconti taking the medication physician's response the recommendation on 5/28/13.  Review of the physici revealed the Director	was checked as accepting and to implement as written an's orders dated 5/28/13 of Nursing (DON) wrote an an signed the order to						
	for the Month of May the resident received	·						
F 428	the Nurse Consultant Vice President of the Nurse Consultant starpharmacist came to the exits he would give whis medication review consultant then would and one half to 2 weet the DON. The DON to the physician and herecommendations barwas supposed to kee sure all the pharmacy acted on. She was to keep a copy of the Because the facility donot know what was started to the sure supposed to keep a copy of the Because the facility donot know what was started on the supposed to keep a copy of the Because the facility donot know what was started on the supposed to the supposed to keep a copy of the Because the facility donot know what was started on the supposed to the supposed to the supposed to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the facility donot know what was started to the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the Because the supposed to keep a copy of the supposed to keep a cop	ne facility on the day he erbal information regarding s. The pharmacy I e-mail his report in about 1 less to the Administrator and would send the consultations he was to return his ck to the facility. The DON p a copy so she could make consultation reports were keep a copy and she failed consultation report. id not have the copy they did	F	128	F-428			
SS=D	IRREGULAR, ACT O				1. Nurses will write a physician's orde (continued)	r for		

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		345262	B. WNG			08/29/2013	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IÐ PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	reviewed at least one pharmacist.  The pharmacist must the attending physici	e 8  each resident must be be a month by a licensed treport any irregularities to an, and the director of sports must be acted upon.	F	428	a lab to be drawn.  2. The physcian's order will be review following day during clinical rounds to the lab has been drawn and placed in pending file awaiting results.  3. As results are received, the lab vareported to the physcian as appropriand the copy removed from the pending the signed and noted copy of the lab report is then filed in the chart.  The DON is ultimatley responsible for ing compliance with this corrective a which will be implemented by 9/25/1	o assure n a lue is ate, noted ding file. poratory or sustain- ction	
	by: Based on medical reconsultant review an failed to act on pharm of 5 (Resident #5 and pharmacy recommer laboratory tests and medication per physipharmacist failed to in medication dosage residents (Resident unnecessary medical).  The findings include:  1. Resident #5 was 8/23/2006 with diagring vascular accident (Carcoldosis, osteoartetinopathy, hypertein anxiety, anemia and Review of the pharm	report to the facility a change of for eye drops for 1 of 5 ff13) reviewed for tions.  admitted to the facility on a ff1 ff1 ff1 ff1 ff1 ff1 ff1 ff1 ff1 f			Resident #22's order for daily vitaming discontinued on 5/28/13 and has not given since.  4. Any resident who has a pharmacy ation recommendation made in the ladys have been reviewed for responsed comprehensiveness of responsed to the form of the follow DON for review, copying, and follow DON will forward recommendations physician's response by mail or hand to the Medical Director for action. The Director will promptly respond by rethe both the cover sheet and a recommendations are transcribed on appropriate orders then recorded on TAR, or other appropriate document.  The Admininstrator is ultimately responsed to the cover sheet and a recommendations are transcribed on appropriate orders then recorded on TAR, or other appropriate document.	consultant 120 consul	

Event ID: CWL811

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345262	B. WING_			C 08/29/2013	
	ROVIDER OR SUPPLIER NTER HEALTH & REHAI	в/не		STREET ADDRESS, CITY, STATE, ZIP COD 1300 DON JUAN ROAD HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 428	During an interview of Nurse Consultant state not get sent to the Phissue; staff did not consultant state of the pharma 7/9/13 revealed a recomme Please respond promomompliance with Feder 5 had orders for labs of this review they we resident record. The PTH (Para Thyroid Herbert PTH (Para Thyroid Herbert PTH) and interview of Nurse Consultant state stimulating hormone) was within normal liming stated staff failed to different processing the lab book and draw TSH. The lab for the been sent to the Physical Puring an interview of Nurse #1 stated where order either by voice of order off. If an order write it in the lab book with the lab book order off. If an order write it in the lab book with the lab book with the lab book order off. If an order write it in the lab book with the lab with the lab book with the lab book with the lab wi	ating a Potassium level. "  n 8/28/13 at 11:00 AM the led the Potassium level did lysician. It was a copying by this order.  acy recommendation of commendation in part, as indation from 6/11/13. ptly to assure facility literal regulations. Resident # to be drawn, but at the time re not available in the missing lab values include: formone). "  n 8/28/13 at 11:00 AM the led staff drew a TSH (thyroid instead of a PTH, the TSH lits. The Nurse Consultant	F	128			
	the orders off and worbook. If there was a	uld process it to the lab problem with that lab, staff ician the lab could not be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345262	B. WING _			C 08/29/2013	
	ROVIDER OR SUPPLIER	AB/HE		STREET ADDRESS, CITY, STATE, ZIP CO 1300 DON JUAN ROAD HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	· ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE RE APPROPRIATE	(X5) COMPLETION DATE	
F 428	revealed staff would hour report and disc in stand up meeting not know why the Pot the lab book.  2. Resident #22 was diagnoses of congest Hypertension and Discount and Disco	is response. Nurse #1 also document on the 24 uss the lab the next morning for follow up. Nurse #1 did otassium or PTH were not on s admitted on 7/3/2017 with stive heart failure (CHF),	F4	128			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRI	(X3) DATE SURVEY COMPLETED		
		345262	B. WING			C 08/29/20	
	ROVIDER OR SUPPLIER	B/HE		1300 DON	DRESS, CHY, STATE, ZIP CODE JUAN ROAD RD, NC 27944	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 428	on 5/28/13.  Review of the physici revealed the Director order and the physicial discontinue the Vitama. Review of the medicator the Month of May the resident received.  During an interview of the Nurse Consultant Vice President of the Nurse Consultant starpharmacist came to the exited he would give his medication review consultant then would and one half to 2 weet the DON. The DON to the physician and is recommendations bath was supposed to kee sure all the pharmacy acted on. She was to to keep a copy of the Because the facility of not know what was significant with the start of the Consultant #13 was 3/14/05 with diagnose Diabetes.  Review of the Quarter (MDS) Assessment of resident as having Gline in the physician and the physician and the pharmacy acted on. She was to the Recause the facility of the Recause the facility of the Recause the facility of the Review of the Quarter (MDS) Assessment of resident as having Gline in the physician and the physician and the recommendations because the facility of the Review of the Quarter (MDS) Assessment of the Review of	and to implement as written an's orders dated 5/28/13 of Nursing (DON) wrote an an signed the order to an in C.  ation administration records 2013 until 5/28/13 revealed vitamin C daily, an 8/29/13 at 12:20 pm with the Administrator and the corporation present, the ted when the facility the facility on the day he verbal information regarding and the consultations the was to return his ck to the Administrator and would send the consultations the was to return his ck to the facility. The DON p a copy so she could make a consultation reports were to keep a copy and she failed consultation report.  Idid not have the copy they did	F	428			
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: C	WL811	Facility ID: 94	43003 If contin	uation shee	Page 12 of 14

	OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345262	B. WING				29/2013	
	ROVIDER OR SUPPLIER	B/HE	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27944					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY)		(X5) COMPLETION DATE	
F 428	Resident #13 having Retinopathy.  Review of the Medica for the month of Augu #13 was receiving Xa the right eye for Glaurented solution (eye drops) veyes.  Review of the Physici documented an order Solution to be given in Glaucoma.  Review of the Medica for March 2013 through Resident #13 receive to the right eye only.  Review of the month documentation from March 2013 did not show an the change in dosage.  During an interview won 8/28/13 at 9:50AM Physicians or orders supplied to the right eye on suppli	on as triggering related to Glaucoma and Diabetic  Intion Administration record lest 2013 revealed Resident latan .005% eye drops to coma.  Intion Administration the resident 's Xalatan were to be given in both  Itan 's orders dated 3/20/13 of for Xalatan Ophthalmic in both eyes nightly for  Intion Administration Records gh August 2013 showed that diabeta Xalatan .005% eye drops  Intion Administration regarding the of the eye drops.  Intion Administration regarding the stated that all hould be followed.	F	428				
	recall the medication  During an interview w	M he stated that he did not change.  with the Administrator on a stated that he would expect						

PRINTED: 09/09/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ С 345262 B. WING 08/29/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD **BRIAN CENTER HEALTH & REHAB/HE** HERTFORD, NC 27944 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 428 Continued From page 13 F 428 the Pharmacy Consultant to review the medical records monthly and if there is a discrepancy to report it to the facility. He further stated the process would be for the consultant pharmacist to check physician's orders and consults for any changes and confirm those changes have been made on the Medication Administration Record.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	,		FORM A	09/30/2019 APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DETICIENCIES (XI) PROVIDER/SUPPLIER/CLA				OMB NO, 0938-0  (X3) DATE SURVEY  COMPLETED  AUILDING 01 - MAIN BUILDING 01				
345282		B, WING						
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
			1 1:	DADS NAUL NOO OBE	•			
BRIANC	ENTER HEALTH & R	EHABIHE	н	HERTFORO, NC 27944				
(X4) ID PREFIX YAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD DROSS-REFERENCED TO THE APPROP DEFICIENCY)	38C	COMPLETION DATE		
K 000 K 018 68≓D	Based on observation on 09/18/2013 the facility was type V. fully sprinkled, protected wiyh(78) seventy-eight beds.  K 018 NFPA 101 LIFE SAFETY CODE STANDARD		K 000  K018  Correction for the alleged deficient noted as rooms 21, 402, and 403 fa latch when closed, was to immediate adjust those doors to reliable work! latching condition. The Maintenance Director surveyed the remainder of building checking all doors for proproperation and made any needed readjustments upon discovery. The					
	minutes, Doors in required to resist the no impediment to the are provided with a the door closed. Doors permitted.	inutes, Doors in sprinklered buildings are brily quired to resist the passage of smoke, There is impediment to the closing of the doors. Doors a provided with a means suitable for keeping a door closed. Dutch doors meeting 19.3.5.3.6		Maintenance Director will do a way survey of all doors for proper oper the next three months and prese findings at the corresponding modern Safety Committee meetings for a discussion. Reviews will continue thereafter until next annual survey continued compliance. Complete 9/19/2013	reekly eration for the state of	d ly ure		
K 082 SS=D	A. Based on obset to rooms 214,402 of closed. 42 CFR 483.70 (a) NFPA 101 LIFE SA Required automatic	AFETY CODE STANDARD o sprinkler systems are alned in reliable operating	K 062			(XO) DAYE		
LADORATOR'	Y DIRECTOR'S OR PROVI	DER/BUPPLIER REPRESENTATIVE'S SIG	NATURE	Administrator	oj	/12/13		

Any deficulty 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 institutions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whather 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 08 program participation.

Facility ID: 943003

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES			FORM	: 09/30/2013 APPROVED		
		(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(K2) MULTIPLE CONSTRUCTION A BUILDING NT - MAIN BUILDING OT		(XS) DATE SURVEY COMPLETED			
345262		8, WIN9 09/18/2013						
NAME OF PROVIDER OR SUPPLIER  BRIAN CENTER HEALTH & REHABI/HE			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 DON JUAN ROAD HERTFORD, NC 27844					
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE		
K 062	periodically. 19.7 25, 9.7.5  This STANDARD is A. Based on observations and sprinkler heads und	ge 1 spected and tested .6, 4.6,12, NFPA 13, NFPA s not met as evidenced by: vation on 09/18/2013 the certhe over hang at the end of re corroded and must be	K 062	Correction for the alleged deficier noted as "sprinkler heads under the overhang at the end of 200 corrid corroded and must be replaced", placed to sprinkler contractor to a Maintenance Director to survey the building and note for replacement and any other sprinkler heads four corroded. The Maintenance Director to survey the monthly inspection sprinkler heads and present all find discussion and review to the next monthly Safety Committee meeting These monthly inspections will the continue to be reviewed by the Safety Committee quarterly thereafter up annual survey to insure continued compliance. Date of correction	he or were was a classist he entir t, those hd to be tor will s of the dings fo three hgs. en ifety ntil nex	all 2		

nenzer	WENT OF HEALTH	AND HUMAN SERVICES				FORM A	09/30/2013 PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				1	938-0391
CANCELLED OF DESIGNATION (X1) PROVIDERISUPPLIERICLIA		(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			COMPLETED (X3) DATE SURVEY		
345262			B. WING 09/18/20				8/2013
NAME OF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
DELAN C	ENTER HEALTH & R	EHARIHE		, , , ,	10 DON JUAN ROAD		
- BRIMIN C	THE TENEDITOR	M. 17 (13)	,	HE	RTFORD, NC 27944		IVE
(X4) ID PREFIX TAG	IFACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE I	COMPLETION COMPLETION OATE
K 000 K 018 SS=D	INITIAL COMMENTS  Based on observation on 09/18/2013 the facility was type V, fully sprinkled, protected with (78) seventy-eight beds.  NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than		K 000		K018 Correction for the alleged deficient pra noted as rooms 21, 402, and 403 failed latch when closed, was to immediately		ce
1	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3,6,3,6 are permitted. 19.3,6,3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: A. Based on obsevation on 09/18/2013 the doors to rooms 214,402 and 403 falled to fatch when closed. 42 CFR 483,70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are			< 062	building checking all doors for properation and made any needed adjustments upon discovery. The Maintenance Director will do a visurely of all doors for proper op the next three months and presentings at the corresponding m Safety Committee meetings for discussion. Reviews will continuate thereafter until next annual survicontinued compliance. Complete 9/19/2013	roper if repairs weekly peration f ent all onthly review ar ic quarte vey to ins	or d fly ure
LABORATO	1	ntained in reliable operating VIDEN/SUPPLIER REPRESENTATIVE'S S	IGNATUR	RE	TITLE	.,	(XO) DATE

Any deficiency statishent 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 of 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. N

PRINTED: 09/30/2013

If continuation sheet Page 2 of 2

		AND HUMAN SERVICES  & MEDICAID SERVICES			O <sub>1</sub>		0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI,IA IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
		345262	B. WiNG			09/1	8/2013
NAME OF I	PROVIDER OR SUPPLIER	<u></u>			TREET ADDRESS, CITY, STATE, ZIP CODE 300 DON JUAN ROAD		
_BRIAN_C	ENTER HEALTH & R	EHAB/HE			ERTFORD, NC-27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	008 1	(X6) COMPLETION DATE
K 062	periodically. 19.7 25, 9.7.5 This STANDARD A. Based on obser sprinkler heads und	nspected and tested r.6, 4.6.12, NFPA 13, NFPA is not met as evidenced by: rvalion on 09/18/2013 the der the over hang at the end of are corroded and must be		062	Correction for the alleged deficie noted as "sprinkler heads under to overhang at the end of 200 corrid corroded and must be replaced", placed to sprinkler contractor to Maintenance Director to survey to building and note for replacemer and any other sprinkler heads for corroded. The Maintenance Director to survey the Maintenance Director to survey the Maintenance Director sprinkler heads and present all find discussion and review to the next monthly Safety Committee meet These monthly inspections will the continue to be reviewed by the Standard and survey thereafter the second survey to th	the dor were was a creasist the entire at, those und to b ctor will as of the adings fo t three lings aren safety until nex	all 2

Event ID; CWL821

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

Facility ID: 943003