PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---------------------|--|--------|----------------------------|
| | | 345317 | B. WING | | 0 | C 5/ 25/2017 |
| | ROVIDER OR SUPPLIER | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY ROAD CLAYTON, NC 27520 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPROPRIED OF T | JLD BE | (X5) COMPLETION DATE |
| F 157 SS=D | (INJURY/DECLINE/R (g)(14) Notification of (i) A facility must imm consult with the resid consistent with his or representative(s) whe (A) An accident involvesults in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter tre a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informati is available and provi physician. (iii) The facility must a resident and the resid when there is- | Changes. rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, real status (that is, a n, mental, or psychosocial reatening conditions or); reatment significantly (that is, a n existing form of erse consequences, or to m of treatment); or | F 157 | | | 6/17/17 |
| ABORATORY | DIRECTOR'S OR PROVIDER/S | SUPPLIER REPRESENTATIVE'S SIGNATUR | RF | TITLE | | (X6) DATE |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 06/16/2017

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.

| 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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| | | 345317 | B. WING | | | C 05/25/2017 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | I | 03/23/2017 | |
| DDIAN OF | NITED III THE O DETIDEN | ENT | | 204 DAIRY ROAD | | | |
| BRIAN CE | NTER HLTH & RETIREM | ENI | | CLAYTON, NC 27520 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 157 | Continued From page | e 1 | F 1 | 57 | | | |
| | as specified in §483.1 | 10(e)(6); or | | | | | |
| | (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must rupdate the address (ruphone number of the This REQUIREMENT by: Based on record reviews, Physician interviews, Physician interviews, Physician of the unaw medications upon addresulted in missed meresidents. (Resident Findings included: Record review reveal admitted to the facility with diagnoses which Congestive Heart Fair Review of Resident #revealed an entry dat Nurse #1. The note in admitted to the facility alert and oriented to part of the section of the se | ent rights under Federal or ns as specified in paragraph. record and periodically mailing and email) and resident representative(s). is not met as evidenced liew, staff, family and the facility failed to notify the railability of ordered mission to the facility which edication doses for 1 of 3 (224) ed Resident #224 was on Saturday, 3/18/2017 included Hypertension and lure. 224's nursing notes ed 3/18/2017 at 8:05 PM by indicated Resident #224 was or from the hospital and was person, place and time. The | | 1. Resident 224 was discharge March 22, 2017. All admissions is March 22 were reviewed by Nurs verified that all medications were administered as currently ordered. All licensed nurses will be re-educated by June 17 that if me has not been received by schedulof admission and is not available e-kit, to notify MD for further order notify DON or designee. 3. Medication orders from the part day will be reviewed by an admir nurse leader to ensure medication received and administered as ord The DON or designee will follow | since sing and being d. edication uled time in the ers and previous histrative ons were dered. up with | | |
| | ordered medications | the resident's Physician were confirmed with the | | any weekend admissions to ensumedications were received by the | e facility | | |
| | within the 3 hour wind Review of the Physici revealed the medicati Medication Administra 3/18/2017. A review of the electra 3/18/2017 a number | be delivered to the facility dow. ian orders dated 3/18/2017 ions were transferred to the ation Record (MAR) on onic MAR revealed on '8" and Nurse #1's initials 9:00 PM for the following | | or the MD was notified. Conducted weekend for four weeks and their thereafter. 4. The DON will report findings QAPI committee monthly for 3 m. The committee will evaluate resumention to ensure continued committee to the committee will evaluate the committee will evaluate resumention to ensure continued committee. | n monthly to the onths. ilts and | | |

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| 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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| | | 345317 | B. WING | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER | L | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 04 DAIRY ROAD CLAYTON, NC 27520 | 1 03/ | 25/2017 |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 157 | for Hypertension) ever Lamotrigine 25mg (a Disorder, mood swing evening Buspirone HCL 15 mg anxiety) twice a day The electronic MAR of "8" signified a progress Progress notes were Entries noted at 9:52 documented the pharmedication. Further review of the 3/19/2017 a number "were documented at 9:60 medications: Valsartan 320mg (a medications: Valsartan 320mg (a medication) every medication every every endication every ev | grams (mg) (a medication by evening medication used for Bipolar grams or seizures) every g (a medication used for codes revealed the number as note had been completed. The reviewed for 3/18/2017. PM by Nurse #1 macy was to deliver MAR revealed on Sunday, 18" and Nurse #2's initials 19:00 AM for the following 19:00 AM for the following 19:00 and (a medication used for morning 19:00 twice a day 19:00 mg (a medication used for morning 19:00 m | F | 157 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | TE SURVEY MPLETED |
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| | | 345317 | B. WING _ | | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER | //ENT | | STREET ADDRESS, CITY, STATE, ZIP CO 204 DAIRY ROAD CLAYTON, NC 27520 | | 0/20/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 157 | reported when the me the electronic medication medications were su 3 hours. Nurse #1 re Emergency Box in the nurses could get men pharmacy did not de medications. Nurse #1 the number "8" on the note indicated the medications they were not available thought if the medications or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the Physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a loreported since she did the physician or Admir to get them from a | or the admission. Nurse #1 edications were entered into al record, the pharmacy of the orders and the pposed to be delivered within ported there was an e Medication Room and the dications from the box if the liver the ordered #1 stated if she documented the MAR and the progress edications were on order alinister the medications of in the emergency box so to le. Nurse #1 indicated she alitions were really needed histration made the decision cal pharmacy. Nurse #1 id not document she called hinistration to inform of the g available, she must not w was conducted with Nurse #20 AM. Nurse #2 reported at #224 and the morning of revealed the pharmacy did | F 1 | | Y) | |
| | resident's condition v A telephone interview family member of Re 10:10 AM. The family | called the DON and since the vas stable. v was conducted with a sident #224 on 5/24/2017 at member stated Resident norning after admission to | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | E CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 345317 | B. WING | | | | 25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00, | 20.2011 |
| | | | | 2 | 204 DAIRY ROAD | | |
| BRIAN CE | NTER HLTH & RETIRE | MENT | | (| CLAYTON, NC 27520 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | (X5) | |
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| F 157 | Continued From page | ge 4 | F | 157 | | | |
| | the facility and repo | rted she had not received all | | | | | |
| | of her medications. | The family member stated | | | | | |
| | she went to the faci | lity and was told by the nurse | | | | | |
| | some of the medica | tions were not available due | | | | | |
| | to an issue with the | pharmacy delivery. | | | | | |
| | | onducted with the Director of | | | | | |
| | | 5/24/2017 at 10:38 AM. The | | | | | |
| | | called the situation with | | | | | |
| | | edication not being available | | | | | |
| | | ne day after admission. The e #2 called her on the | | | | | |
| | | 17 and reported the pharmacy | | | | | |
| | _ | ne ordered medications for | | | | | |
| | | DON said she was not | | | | | |
| | | before when some of the | | | | | |
| | _ | navailable for administration. | | | | | |
| | The DON stated sh | e did not ask Nurse #2 if the | | | | | |
| | Physician was notifi | ied. The DON stated she | | | | | |
| | asked about the res | sident's condition and Nurse | | | | | |
| | | dent was calm and her blood | | | | | |
| | | The DON reported the facility | | | | | |
| | | d medications from a local | | | | | |
| | | needed and did not know | | | | | |
| | | nacy was not utilized for | | | | | |
| | | DON stated the expectation | | | | | |
| | Physician to be noti | trative Nurse on call and the | | | | | |
| | medications are una | | | | | | |
| | | onducted with the resident's | | | | | |
| | | 5/24/2016 at 2:12 PM. The | | | | | |
| | | he was unaware of the | | | | | |
| | | the resident's medications on | | | | | |
| | | sician stated the nursing staff | | | | | |
| | | nes with pharmacy delivery | | | | | |
| | delays and his resp | onse depended on the | | | | | |
| | specific medications | s and the resident's condition. | | | | | |
| | | rted he could not say how he | | | | | |
| | | ded to the resident's situation. | | | | | |
| | The Physician state | d he expected to be notified if | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | 2) MULTIPLE CONSTRUCTION BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 204 DAIRY ROAD CLAYTON, NC 27520 | I)E | 03/23/2017 | |
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| F 157 F 281 SS=D | within the required tin 483.21(b)(3)(i) SERV PROFESSIONAL ST. (b)(3) Comprehensive The services provide as outlined by the commust- (i) Meet professional This REQUIREMENT by: Based on observation family and physician to administer medicar the following morning in missed doses of maresidents reviewed (Facility failed to provide for 1 of 1 resident administer wound healing Findings included: 1. Record review reveadmitted to the facility diagnoses which included: Congestive Heart Fair Resident #224 was diagnoses of the Dischaller with the service of the Dischaller with the service with the serv | available for administration neframe. ICES PROVIDED MEET ANDARDS e Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced ns, record review and staff, interviews, the facility failed tions on admission date and as ordered which resulted edications for 1 of 3 Resident #224); and the de a nutritional assessment mitted with wounds which initiate supplements to ing (Resident #151). ealed Resident #224 was yon 3/18/2017 with uded Hypertension and lure. Record review revealed ischarged to home on rge Minimum Data Set | F 15 | 1. RD re-educated Dietary current policy and procedure assessment completed accor schedule and within 7 days or Completed 6/13/17 2. RD to be emailed weekly report by the facility wound cawith residents who have beer with wounds or acquired wou facility. RD will also receive a wound and nutritional interventions/recommendation and ongoing. RD to review most current woreview each resident and mal recommendations if needed. 3. RD will conduct weekly week | Manager on to have rding to MDS f admission. wound are nurse n admitted inds in the consult for ms. 6/13/17 bund report, ke | 6/17/17 | |
| | There was no other N Care Plan information resident's length of st | t was cognitively intact. MDS assessment or any n available due to the | | reports and submit them to the 4. Weekly wound audit reported monthly at QAPI me 3 months of 100% compliance achieved. | orts will be eetings until | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | | E CONSTRUCTION | (X3) DATE COMP | SURVEY PLETED | |
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| | | 345317 | B. WING | | | 1 | C 25/2017 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 20/2011 | |
| DDIAN CE | NTED ULTU & DETIDEM | IFNT | | 2 | 204 DAIRY ROAD | | | |
| BRIAN CE | NTER HLTH & RETIREM | IENI | | (| CLAYTON, NC 27520 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
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| F 281 | Continued From page | | F: | 281 | | | | |
| | | 117 at 8:05 PM by Nurse #1. | | | | | | |
| | | esident #224 was admitted | | | | | | |
| | , | hospital and was alert and | | | | | | |
| | | ace and time. The note | | | | | | |
| | | esident's vital signs were | | | | | | |
| | | ian ordered medications | | | | | | |
| | | the pharmacy and would be y within the 3 hour window. | | | | | | |
| | The hospital discharg | | | | | | | |
| | | report of the resident's | | | | | | |
| | condition was called t | - | | | | | | |
| | | the hospital and included the | | | | | | |
| | | ere administered at the | | | | | | |
| | hospital. The discharg | ge form revealed the | | | | | | |
| | resident did not recei | ve evening medications prior | | | | | | |
| | to the facility transfer. | | | | | | | |
| | Review of the Physici | ian orders dated 3/18/2017 | | | | | | |
| | | ions were transferred to the | | | | | | |
| | Medication Administra 3/18/2017. | ation Record (MAR) on | | | | | | |
| | | nt's electronic MAR revealed | | | | | | |
| | | er "8" and Nurse #1 initials | | | | | | |
| | medications: | 9:00 PM for the following | | | | | | |
| | | grams (mg) (a medication | | | | | | |
| | for Hypertension) eve | • | | | | | | |
| | | medication which was | | | | | | |
| | | isorder) every evening | | | | | | |
| | ordered for anxiety) to | g (a medication which was | | | | | | |
| | · · · | <u> </u> | | | | | | |
| | | codes revealed the number ss note was completed. | | | | | | |
| | | reviewed for 3/18/2017. | | | | | | |
| | Entries noted at 9:52 | | | | | | | |
| | documented the phar | | | | | | | |
| | medication. | | | | | | | |
| | | MAR revealed on 3/19/2017 | | | | | | |
| | a number "8" and Nu | | | | | | | |
| | documented at 9:00 A | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING _ | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER | MENT | | STREET ADDRESS, CITY, STATE, ZIP CO 204 DAIRY ROAD CLAYTON, NC 27520 | • | 1012012011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 281 | Hypertension) every Progress notes were note at 11:36 AM by medications were on pharmacy and family No further document medications was not An interview was con 5/24/2017 at 8:45 AN worked the weekend recall Resident #224 reported when the medications were suddications were suddications. Nurse #1 in arrived late in the aft sometimes she calle sure they would be of there were times the medications until the next day. Nurse #1 remergency Box in the nurses could get me pharmacy did not demedications. Nurse with the number "8" on the note indicated the medicated she though really needed some of the decision to get the really needed some of the decision to get the sure of th | medication used for morning growing twice a day 60 mg (a medication used for morning reviewed for 3/19/2017. A Nurse #2 documented the order, call back up was to bring the AM dose. ation of the missed ed. Inducted with Nurse #1 on M. Nurse #1 reported she of 3/18/2017 but did not or the admission. Nurse #1 edications were entered into al record, the pharmacy of the orders and the pposed to be delivered within dicated when residents ernoon on the weekends, delivered within 3 hours, but pharmacy did not deliver the 11:00 PM delivery or the eported there was an ine Medication Room, and the dications from the box if the | F 2 | 81 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ' ' | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING _ | | | C 95/25/2017 | |
| | ROVIDER OR SUPPLIER | MENT | | STREET ADDRESS, CITY, STATE, ZIP CO 204 DAIRY ROAD CLAYTON, NC 27520 | | 312312011 | |
| (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 E APPROPRIATE | (X5) COMPLETION DATE | |
| F 281 | inform of the medical must not have called A telephone interview #2 on 5/24/2017 at 9 she recalled Resider 3/19/2017. Nurse #2 not deliver the admis Resident #224. Nurse medications were available. Nurse was visiting the resident was visiting the resident said she called the D was informed the medications were later family member had seen medications were later family member went some of the resident recall which ones. Nurse administered the medications were later family member went some of the resident recall which ones. Nurse administered the medications were later for the properties of the proper | cian or Administration to tions not being available, she d. w was conducted with Nurse 2:20 AM. Nurse #2 reported at #224 and the morning of a revealed the pharmacy did asion medications for the #2 indicated some of the available in the Emergency stered the medications which the #2 stated a family member and stated she had some dication at home. Nurse #2 Director of Nursing (DON) and addication could be given if the some available and the some and returned with the some and returned with the some and returned with the some and thought she in the 24 hour report. Nurse the properties and thought she in the 24 hour report. Nurse the sone on thing would be missed and contained information so nothing would be missed and the report shifts were a daily review. Nurse #2 ared checking the resident's the medications which were or Hypertension. Nurse #2 blood pressure was ok. The did not call the physician. The or 3/19/2017 was reviewed on of administration of home | F 2 | 81 | | | |

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| | | 345317 | B. WING | | | | 25/2017 |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00. | 20/2011 |
| | | | | 2 | 204 DAIRY ROAD | | |
| BRIAN CE | ENTER HLTH & RETIRE | MENT | | (| CLAYTON, NC 27520 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | , | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREF TAG | | (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | | COMPLÉTION DATE |
| F 281 | Continued From pag | ne 9 | F | 281 | | | |
| | | esident #224 on 5/24/2017 at | | | | | |
| | | y member stated Resident | | | | | |
| | | morning after admission to | | | | | |
| | | ted she had not received all | | | | | |
| | - | e family member went to the | | | | | |
| | | the nurse she had some of | | | | | |
| | | medications. The family | | | | | |
| | | nurse called someone in | | | | | |
| | | they said it was ok for the | | | | | |
| | | medications from home. The | | | | | |
| | | rted both the medications she | | | | | |
| | | ent were for Hypertension. | | | | | |
| | An interview was co | nducted with the DON on | | | | | |
| | 5/24/2017 at 10:38 A | AM. The DON stated she | | | | | |
| | recalled the situation | n with the medication of | | | | | |
| | Resident #24 not be | ing available for | | | | | |
| | administration the da | ay after admission. The DON | | | | | |
| | reported Nurse #2 ca | alled her and reported the | | | | | |
| | pharmacy did not de | liver the medications for the | | | | | |
| | resident and there w | as a family member visiting | | | | | |
| | the resident who sai | d she had the resident's | | | | | |
| | Hypertension medical | ations from home. The DON | | | | | |
| | | Nurse #2 it would be fine to | | | | | |
| | • | from home as long as they | | | | | |
| | | ttle. The DON stated if the | | | | | |
| | | alled for stat delivery the | | | | | |
| | - | irs to deliver the medications. | | | | | |
| | | considered medications for | | | | | |
| | | s stat orders. The DON | | | | | |
| | | facility expectation was for | | | | | |
| | | to be delivered to the facility | | | | | |
| | | nd if the pharmacy could not | | | | | |
| | | by needed to notify the facility | | | | | |
| | | harmacy. The DON also | | | | | |
| | | on was for all medications, | | | | | |
| | | ere brought from home to be | | | | | |
| | | e medication administered, | | | | | |
| | the dosage and time | | | | | | |
| | An interview was co | nducted with the resident's | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|---|----------------------------|
| | | 345317 | B. WING | | | C 5/25/2017 |
| | ROVIDER OR SUPPLIER | MENT | | STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY ROAD CLAYTON, NC 27520 | , , <u>, , , , , , , , , , , , , , , , , </u> | <u> </u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 281 | Continued From pag | e 10 | F 28 | 31 | | |
| | facility physician on sphysician reported his specific issues with the admission. The physician reported his specific medications. The physician report would have responded the physician report from home, he expecific medications administed admission and admission or any order pharmacy manager worked with the facil scheduled and triage to coordinate deliver reported the pharmation of AM to 3:00 PM on-call after hours. The pharmacy document 3/18/2017 at 8:09 PM the pharmacist to se that night, and the result of suckey pharmacist to se that night, and the result of suckey pharmacist to se that night, and the medicat the backup pharmacist to se the pharmacist to se that pharmacist to se that night, and the result of the pharmacist to se that night, and the medicat the backup pharmacist to se that pharmacist to se that pharmacist to se that night, and the medicat the backup pharmacist to se that pharmacist to se th | 6/24/2016 at 2:12 PM. The e was unaware of the he resident's medications on ician stated the nursing staff es with pharmacy delivery nse depended on the and the resident's condition. ed he could not say how he ed to the resident's situation. ed if medications were given cted documentation of the and specifics of the tered. v was conducted with the nager on 5/24/2017 at 3:05 nanager reported there was ow of delivery time for lered medications. The stated the pharmacy staff ity on the next doses ed when next doses were due y. The pharmacy manager cy is open on Saturdays from 1, and there was someone the pharmacy manager obarmacy completed a ys to cover late Saturday other orders which may need macy manager stated the ation for Resident #244 on If reported Nurse #1 informed and the controlled medications mainder could wait for the e pharmacy manager also ation reported Nurse #1 was tions would be available at y by 11:00 PM on 3/18/2017. ger stated she was unsure | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345317 | B. WING | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY ROAD CLAYTON, NC 27520 | 05/25/2017 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION |
| F 281 | PM revealed the DO medications to be pharmacy. The DO informed by the pharmacy admissions or state 2-Record review readmitted to the faci which included righ Congestive Heart F. Record review of the Policy with a revision revealed a nutrition completed within 7 residents identified skin integrity. Review of the resid Data Set (MDS) daresident was cognit on his right foot. Review of the Care dated 4/14/2017 readmitted with a right extremity and right. The information list Care Plan was devissues. Record review of the included a focus and related to a right diallower extremity and The interventions list required supplement vitamins and mineral wound healing. Record review of the supplement of the pharmacy in the pharmacy i | Per DON on 5/24/2017 at 4:00 ON was unaware of any pricked up at a backup N stated she was never armacy there was no pricked of delivery time for medications. Provealed Resident # 151 was lity on 4/7/2017 with diagnoses are Diabetic Foot Ulcer and | F 28 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | l\ / | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING | | | C 05/25/2017 | |
| | ROVIDER OR SUPPLIER | EMENT | • | STREET ADDRESS, CITY, STATE, ZIP 204 DAIRY ROAD CLAYTON, NC 27520 | • | 0.20.2011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 281 | April 2017 and Ma administration of n An interview was con 5/25/2017 at 1: one of the interver residents admitted supplements to as MDS Nurse stated were initiated by the really sure who initiated supplements who initiated she did norders for resident ensure the supplements who interview was consumed to the supplements who interview was consumed to the Nutritionist. The Nutritionist was made a copy of the week to her on Wedness An interview was consumed to her on Wedness An interview was consumed to the Nutritionist was made a copy of the week to her on Wedness An interview was considered when a report to obligations at other on the shead of the supplements to be supplements to | stration Records (MAR) for y 2017 revealed no utritional supplements. Conducted with the MDS Nurse 19 PM. The MDS Nurse stated ations on care plans for with wounds was nutritional sist with wound healing. The she thought the supplements he treatment nurse but was not triated them. The MDS Nurse of go back and review the sadmitted with wounds to ments were ordered because were supposed to be ordered wounds. Conducted with the Treatment 7 at 1:40 PM. The Treatment was aware all residents with red nutritional supplements by the Treatment Nurse stated the ade aware of all new wounds by the difference of the supplement of | F | 281 | | | |

| 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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| | | 345317 | B. WING | | 1 | C / 25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 123/2017 |
| BRIAN CE | NTER HLTH & RETIREM | ENT | | 204 DAIRY ROAD CLAYTON, NC 27520 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 281 | always informed. In an interview with the PM, the DON indicate for the ordered supple wounds. The DON stawas residents admitted evaluated by the RD aper the facility policy. An interview with the conducted on 5/25/20 physician stated if the did not address the near supplements for resid was brought to his attended. The physician state addressed by the RD admitted with wounds 483.45(a)(b)(1) PHAFACCURATE PROCEITION (a) Procedures. A fact pharmaceutical service that assure the accuratispensing, and admition biologicals) to meet the pharmacist who (1) Provides consultated provision of pharmaceutical provision pharmaceutical provision of pharmaceutical provision ph | ted with wounds but was not the DON on 5/25/2017 at 2:07 ted the RD was responsible tements for any identified ted the facility expectation ted with wounds would be within 7 days of admission tresident's physician was to 17 at 2:16 PM. The te RD or the Wound Nurse ted for nutritional tents with wounds and if it tention, he addressed the tetated the expectation was tal supplements would be when residents were to per the facility policy. The RMACEUTICAL SVC - DURES, RPH totility must provide tees (including procedures tate acquiring, receiving, nistering of all drugs and the needs of each resident. The facility must the services of a licensed tion on all aspects of the ty services in the facility; to is not met as evidenced tiew and staff, family and | F2 | 1. Resident 224 was discharged on March 22, 2017. All admissions since | | 6/17/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING | | | C 05/25/2017 |
| | ROVIDER OR SUPPLIER | IENT | | STREET ADDRESS, CITY, STATE, ZIP CO 204 DAIRY ROAD CLAYTON, NC 27520 | DDE | 39/20/20 11 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY 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 HE APPROPRIATE | (X5) COMPLETION DATE |
| F 425 | of pharmacy ordered in missed doses of maresidents. (Resident The findings included Record review revea admitted to the facilit diagnoses which incled Congestive Heart Fareview of the resider an entry dated 3/18/2 #1. The note indicate ordered medications pharmacy and would within the 3 hour windered the medication Administra 3/18/2017. A review of the electra 3/18/2017 a number were documented at medications: Terazosin HCL 5 mill for Hypertension) Lamotrigine 25mg (a Disorder, mood swind Buspirone HCL 15 manxiety) The electronic MAR (8 "8" signified a progree Progress notes were Entries noted at 9:52 documented the pharmedication. | procedures for the acquisition medications, which resulted dedications for 1 of 3 #224) discled Resident #224 was yon 3/18/2017 with uded Hypertension and illure. In this nursing notes revealed 2017 at 8:05 PM by Nurse doubled the resident the physician were confirmed with the be delivered to the facility dow. It is not a state of the ation Record (MAR) on the state of the facility dow. It is not a state of the ation Record (MAR) on the state of the ation Record (MAR) on the state of the following the state of the following the state of the stat | F 4 | March 22 were reviewed by verified that all medications administered as currently or 2. All licensed nurses will re-educated by June 17, 20 medication has not been received time of admission available in the e-kit, to notif further orders and notify DO designee. 3. Omnicare started a new service on May 1, 2017 in or improve delivery reliability. And re-admissions on Sature Sunday will be communicate pharmacy as stat orders and to the facility on the next dais schedule. 4. The DON will report find QAPI committee monthly for The committee will evaluate monitor to ensure continued. | were being dered. be 17 that if beived by and is not by MD for N or v courier reder to all admissions day and bed to the divil be sent by delivery dings to the 3 months. results and | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION B | COM | (X3) DATE SURVEY COMPLETED | | |
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| | | 345317 | B. WING | | l | C / 25/2017 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 204 DAIRY ROAD CLAYTON, NC 27520 | 03 | 729/2017 | | |
| (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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | | |
| F 425 | Progress notes were note at 11:36 AM by medications were or pharmacy and family. No further documen medications was not An interview was co 5/24/2017 at 8:45 Al worked the weekend recall Resident #222 reported when the number electronic medications were so 3 hours. Nurse #1 in arrived late in the af sometimes she wou sure they would be of there were times the medications until the next day. Nurse #1 in Emergency Box in the nurses could get me pharmacy did not demedications. Nurse the number "8" on the note indicated the moder they were not availate thought if the medicasomeone from Admit | medication used for g 60 mg (a medication used for e reviewed for 3/19/2017. A Nurse #2 documented the n order, call back up y was to bring the AM dose. tation of the missed ted. nducted with Nurse #1 on M. Nurse #1 reported she d of 3/18/2017 but did not d or the admission. Nurse #1 nedications were entered into all record, the pharmacy of the orders and the upposed to be delivered within dicated when residents ternoon on the weekends, ld call the pharmacy to make delivered within 3 hours but e pharmacy did not deliver the e 11:00 PM delivery or the reported there was an ne Medication Room and the dications from the box if the | F 42 | | | | | |

| 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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| | | 345317 | B. WING | | | | C | |
| NAME OF D | ROVIDER OR SUPPLIER | 343317 | B: Wii(0 _ | ς. | TREET ADDRESS, CITY, STATE, ZIP CODE | 05/ | 25/2017 | |
| NAME OF T | TOVIDER OR SOLT EIER | | | | | | | |
| BRIAN CE | NTER HLTH & RETIREM | MENT | | | 04 DAIRY ROAD | | | |
| | | | | С | LAYTON, NC 27520 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 425 | Continued From pag | e 16 | F4 | 125 | | | | |
| F 425 | reported since she dithe physician or Adminedications not bein have called. A telephone interview #2 on 5/24/2017 at 9 she recalled Resider 3/19/2017. Nurse #2 not deliver the admis Resident #224. Nursimedications were avand she had administ were available. Nursipharmacy and they it would be delivered to A telephone interview family member of Refunding member of Refunding and report her medications. The facility and report her medications. The facility and was infort the resident's medication to a problem with the member reported she medications for Hype called Administration the home medication An interview was con Nursing (DON) on 5/DON stated she recalled Resident #224's medications and the short recalled reca | id not document she called inistration to inform of the g available, she must not wwas conducted with Nurse :20 AM. Nurse #2 reported at #224 and the morning of revealed the pharmacy did is ion medications for e #2 indicated some of the ailable in the Emergency Box itered the medications which e #2 stated she called the informed her the medications ater in the afternoon. If wwas conducted with a sident #224 on 5/24/2017 at with morning after admission to ited she had not received all ite family member went to the informed by the nurse some of ations were not available due in pharmacy. The family ite had the resident's home intension, and the nurse for permission to administer | F 2 | 125 | | | | |
| | DON reported Nurse the pharmacy did no Resident #224 and the visiting the resident was some of her meds from | #2 called her and reported t deliver the medications for here was a family member who said she could bring in om home. The DON stated #2 it would be fine to give the | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING | | | 05/ | 25/2017 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 20 | 04 DAIRY ROAD | | |
| BRIAN CE | NTER HLTH & RETIRE! | MENT | | С | LAYTON, NC 27520 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 425 | labeled bottle. The D | ge 17 ne as long as they were in a DON stated if the medications livery the pharmacy had 3 | F | 425 | | | |
| | hours to deliver the r she considered med admissions stat orde indicated the facility | medications. The DON stated ications for weekend ers. The DON further expectation was for ordered | | | | | |
| | the 3 hours and if the | elivered to the facility within e pharmacy could not deliver, and to notify the facility so they backup pharmacy. | | | | | |
| | An interview was con facility Physician on | nducted with the resident's 5/24/2016 at 2:12 PM. The ne was unaware of the | | | | | |
| | specific issues with t admission. The Phys | the resident's medications on sician stated the nursing staff netimes with pharmacy | | | | | |
| | delivery delays and I the specific medicati | his response depended on ons and the resident's cian reported he could not | | | | | |
| | say how he would ha #224's situation. The | ave responded to Resident ephysician further stated the | | | | | |
| | | the pharmacy to deliver in a timely manner to ensure as doses. | | | | | |
| | facility pharmacy ma | w was conducted with the anager on 5/24/2017 at 3:05 | | | | | |
| | no guaranteed windo | manager reported there was ow of delivery time for dered medications. The | | | | | |
| | pharmacy manager worked with the facil | stated the pharmacy staff ity on when the next doses | | | | | |
| | pharmacy manager open on Saturdays f | to coordinate delivery. The reported the pharmacy is from 10:00AM to 3:00 PM and | | | | | |
| | pharmacy manager | on-call after hours. The further reported the d a sweep run on Sundays to | | | | | |
| | | admissions and any other | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | | | | С | | |
| | | 345317 | B. WING _ | | | 05/ | 25/2017 | |
| | ROVIDER OR SUPPLIER NTER HLTH & RETIREM | ENT | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 DAIRY ROAD LAYTON, NC 27520 | | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 425 | 8:09 PM reported Nur pharmacist to send the that night and the rem Sunday delivery. The stated the documental informed the medication the backup pharmacy PM on 3/18/2017. The she was unsure why to picked up. An interview with the PM revealed the DON medications to be pict pharmacy. The DON informed by the pharm guaranteed window of admissions or state med 483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMBI QUARTERLY/PLANS) (g) Quality assessment (1) A facility must main and assurance comminimum of: (ii) The director of nurse (iii) The Medical Direction of the staff, at least one of we staff, | ed to be filled. The tated the pharmacy sident #224 on 3/18/2017 at rese #1 informed the e controlled medications nainder could wait for the pharmacy manager also attion reported Nurse #1 was sons would be available at rin Smithfield NC by 11:00 e pharmacy manager stated the medication was not DON on 5/24/2017 at 4:00 N was unaware of any ked up at a backup stated she had never been macy there was no f delivery time for edications. (i)(ii)(h)(i) QAA ERS/MEET Int and assurance. Intain a quality assessment ittee consisting at a sing services; Iter or his/her designee; Iter members of the facility's who must be the a board member or other | | 520 | | | 6/17/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345317 | B. WING _ | | | C 05/25/2017 | | |
| NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HLTH & RETIREMENT | | | | STREET ADDRESS, CITY, STATE, ZIP COD 204 DAIRY ROAD CLAYTON, NC 27520 | | 39,29,2011 | | |
| (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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | | |
| F 520 | Continued From page | | F 5 | 520 | | | | |
| | committee must : | essment and assurance errly and as needed to | | | | | | |
| | coordinate and evalu | ate activities such as n respect to which quality | | | | | | |
| | | ement appropriate plans of tified quality deficiencies; | | | | | | |
| | Secretary may not re- records of such comm such disclosure is rel | rmation. A State or the quire disclosure of the nittee except in so far as ated to the compliance of the requirements of this | | | | | | |
| | by: | and correct quality e used as a basis for is not met as evidenced | | | | | | |
| | Assesment and Assu failed to maintain and were put into place 1/2 were originally cited is survey of 12/21/16 ar recertification survey were in the areas of smedications ordered pharmacy in a timely facility during two fed | I review, the facility Quality rance (QA) Committee I monitor interventions that //16/17. These interventions in the complaint investigation and recited in the of 5/25/17. The deficiencies | | 1. An ad hoc QAPI meeting 6/14/2017 to discuss timely discuss timely discuss timely discuss timely discuss and re-admissions and re-admissions and re-admissions. Pharmacy cut-off and deliver guide was implemented on 6.2. Nurses have been re-ed ADON on pharmacy cut-off times and physician notification required and physician notification required and physician administration himplemented an Admission Maudit tool to monitor medications. | delivery of for ns. A revised y timeline /22/17. ucated by the imes and y procedures quirements. as | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | l l | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345317 | B. WING _ | | | | C 25/2017 | |
| | ROVIDER OR SUPPLIER | IENT | | 20 | TREET ADDRESS, CITY, STATE, ZIP CODE 14 DAIRY ROAD LAYTON, NC 27520 | 1 00/ | 20/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 520 | effective QAA program Findings include: This citation is cross 1. F281 in which the medication ordered or pharmacy for one of the facility was cited complaint survery for medications ordered pharmacy in a timely 2. F425 in which the findication ordered or pharmacy for one of the facility was cited complaint survey for medication ordered or pharmacy for one of the facility was cited complaint survey for medications on admistimely manner. During an interview or Administrator stated, issues with pharmacy our QA meeting on 44 audits and did not see the audits. My expect deliver medications ware ordered or to call pick them up. I expect | referenced to: facility failed to provide an admission from the three residents reviewed at F281 during the 12/16/16 failing to obtain ordered on admission from the manner. facility failed to provide an admission from the three residents reviewed at F281 during the 12/16/16 failing to obtain ordered at F281 during the 12/16/16 failing to obtain ordered ession from the pharmacy in a an 5/24/17 10:30 AM, the "We have been having y and it was brought up in /13/17 and we did some e any issues so we stopped etation is that pharmacy will yithin the 3 hours after they them to back up so we can ct the nurses to notify the | F | 520 | and physician notification if necessary. 4. The QAPI committee will meet monthly for the next three months to monitor data from the Admission Medication Audit tool. Results will be evaluated until 3 months have occurre with zero medication delivery and physician notification problems. | | | |
| | deliver medications ware ordered or to call pick them up. I expensively physicians of the mediand any medication adocumented with medinterview on 5/25/17 Nursing stated the Quitarion of the call pick and the call pic | within the 3 hours after they them to back up so we can ct the nurses to notify the dications not being available | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED | |
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| | | 345317 | B. WING | · · · · · · · · · · · · · · · · · · · | C 05/25/2017 | |
| NAME OF PRO | OVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| BRIAN CEN | ITER HLTH & RETIREM | IENT | | 204 DAIRY ROAD | | |
| | | | | CLAYTON, NC 27520 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE COMPLETION | |
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