PRINTED: 02/26/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(XS	(X3) DATE SURVEY COMPLETED	
		345011	B. WING_			C 01/22/2018	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE	01/22/2010	
BRIAN CE	NTER NURSING CARE/L	EXI		279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			
(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 X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
F 842	conduct a complaint s 1/21/18. Additional int 1/22/18. Therefore, th 1/22/18. Resident Records - Id	formation was obtained on le exit date was changed to lentifiable Information	F 8	342		2/9/18	
SS=E	§483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of	nt-identifiable information. elease information that is o the public. lease information that is					
	•	dance with accepted is and practices, the facility all records on each resident ented; e; and					
	all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay	r their resident permitted by applicable law;					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Electronically Signed 02/05/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345011	B. WING		C 01/22/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		01/22/2010	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.	
F 842	neglect, or domestic activities, judicial an law enforcement pur purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medicator for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 yelegal age under State §483.70(i)(5) The minor (i) Sufficient information (ii) A record of the recipion (iii) The comprehension provided; (iv) The results of an and resident review determinations condition (v) Physician's, nursiprofessional's progregical forms (vi) Laboratory, radio services reports as in This REQUIREMENT)	activities, reporting of abuse, violence, health oversight dadministrative proceedings, roses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or all records must be retained e required by State law; or the date of discharge when ent in State law; or ears after a resident reaches the law. edical record must containtion to identify the resident; esident's assessments; sive plan of care and services any preadmission screening evaluations and fucted by the State; e's, and other licensed	F 84	Company policy requires that facility		
	facility failed to main	tain complete and accurate edication administration of		clinical management (CM) must accourable for all controlled substance medication		

OLIVILIV	OT OIL MEDIONILE G	WIEDIO/ ND OEITVIOLO				CIVID ITC	2. 0000 0001	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NITIMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	_			С	
		345011	B. WING			01/	22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER NURSING CARE	LEXI			79 BRIAN CENTER DRIVE EXINGTON, NC 27292			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 842	Continued From page	e 2	F	842				
		dent #1 and Resident #2) of			all times. Clinical management must			
		for accurate documentation.			document all doses of medication			
	Findings included:				administered on the Medication			
	-				Administration Record (MAR). CM is to)		
	1. Resident #1 had a	n order for Xanax 1 mg			initial the MAR only after the medication	n		
	tablet to be given eve	ery morning and at bedtime.			has been administered. When			
					administering a controlled substance,			
		n the Controlled Medication			CM must also sign for the dose on the			
		MUR) indicated Resident #1			Resident-Specific Declining Inventory			
	medication cart on 11				Record (also known as the Controlled Medication Utilization Record(CMUR).			
	Inedication cart on Ti	1/24/17 at 6.00 FW.			Based on the findings of the survey, C			
	An "Orders- Administ	tration" note for the Xanax			failed to document administration of a	141		
		55 PM stated, "Pharmacy			controlled substance appropriately on	all		
		ted." The documentation in			required forms.			
		nistration Record (MAR)			Resident #1 attending physician was			
	indicated Resident #7	1 did not receive her bedtime			notified on 1/21/18 of omitted			
	dose of Xanax on 11/	/25/17.			documentation for Norco on medication	n		
					order for 12/5/17, 12/6/17, 12/9/17,	_		
		n the MAR indicated Nurse			12/23/17, 12/24/18, 12/29/17, 12/30/1			
		ordered dose of Xanax to			12/31/17, and 1/1/18. The facility Dire	ctor		
	Resident #1 at 8:00 A	AWI ON 11/26/17.			of Nursing completed medication variances for each date of omitted			
	Nurse #1 was intende	ewed on 1/22/18 at 11:43			documentation.			
		she probably got the Xanax			accumonation.			
		up but she did not remember			Resident #2 attending physician was			
	Resident #1 or that p	•			notified on 1/21/17 of the omitted			
		tated it was possible the			documentation for the administration of	of		
	medication Xanax wa	as not administered.			Oxycodone HCL on 1/13/18, 1/14/18,			
					1/21/18, 1/15/18, 1/18/18, and 1/19/18			
		ration" note for the Xanax			The Facility Director of Nursing comple			
		4 PM stated, "Need hard			medication variances for each date of			
	•	ntation in the MAR indicated			omitted documentation.			
	Xanax on 11/26/17.	eceive her bedtime dose of			The facility Director of Nursing will pro	vida		
	Λατίαλ UTI 11/2U/17.				re-education regarding controlled	viuc		
	The documentation in	n the MAR indicated Nurse			medication documentation for nurse's			
		ordered dose of Xanax to			1,2,3,4,5 by 2/9/18.			
	Resident #1 at 8:00 A				.,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345011	B. WING			C 01/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/2	22/2010
	NTER NURSING CARE/	LEXI		27	79 BRIAN CENTER DRIVE EXINGTON, NC 27292		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	AM. Nurse #2 stated dose of Xanax for Re supply in the facility. It utilization record of the back up supply would dose of Xanax from the Director of Nursing on 1/22/18 at 10:15 And spoken with the patated it was the respt to pull a report weekly utilization record and reconciliation. She stapulled by the former to confirm the doses taken from the back was unobtainable. Resident #1 had an omg 1 tablet by mouth Resident #1 also had 5-325 mg 1 tablet by as needed. The documentation in indicated Nurse #3 addose of Norco to Resident #1 at 8:00 Find the documentation in the many states and the former than the many states and the former than the many states and the former than the former than the many states and the former than the former than the many states and the former than the form	ewed on 1/22/18 at 10:45 she knew she pulled the sident #1 from the back up She stated she thought a he medication pulled from the diprove she had taken the he back up supply. Ing (DON) was interviewed had. The DON stated that she charmacy that morning. She honsibility of the former DON hy from the back up supply give it to the pharmacy for hated this report had not been DON and the documentation of Xanax for Resident #1 hip supply in November 2017 Forder for Norco Tablet 5-325 given every 12 hours. In order for Norco Tablet mouth given every 6 hours In the CMUR on 12/4/17 Indiministered the ordered ident #1 at 8:10 PM. The CMUR also indicated Nurse ordered dose of Norco to PM. In the MAR on 12/4/17 Indiministered a scheduled ident #1 at 8:00 PM and an	F	842	The facility clinical manager's (Director Nursing and Unit Manager's) will comp an audit of the last 30 days medication records and Controlled Medication Utilization Record by 2/9/18 to ensure the narcotic medications that were documented as given are reflected on both documents. Any variances in the medication record and/or Controlled Medication Utilization Record will be documented on medication variance reports and the attending physician will notified. The facility licensed nurses will be provided re-education by the Director of Nurses regarding controlled medication documentation 2/9/18. Any facility licensed nurse that does not receive re-education by completion date will not work until they have received re-education. Newly hired nurses will receive the education regarding medication documentation during orientation. The facility clinical managers will review sampled residents on each unit receiving narcotics to ensure that medications are documented on the medications record and controlled medications utilization record daily for thirty days then bi-week times four weeks. The Director of Nursing will report the audit findings to the Quality Assurance Improvement Committee monthly times three. The Quality Assurance Improvement Committee will evaluate to the provided residents and the provided residents will evaluate to the provided residents and the provided residents wille	lete that I be of n ot w 2 ng re I	

Facility ID: 923005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		L. IDENTIFICATION NITIMBED:		PLE CONSTRUCTION		TE SURVEY MPLETED
		345011	B. WING _		,	C 1/22/2018
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		1/22/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842	Nurse #3 stated she doses of Norco at 8:0 12/4/17. Nurse #3 stated sheen going on for me Narc sheet (CMUR). The documentation in #4 administered as in Resident #1 on 12/5/4:00 PM, 12/23/17 at PM, 12/29/17 at 3:30 1/2/18 at 4:30 PM. There was no docum indicate Nurse #4 ad doses of Norco to Readministration times. Nurse #4 was intervied AM. Nurse #4 stated CMUR, then the med Resident #1 on those stated that the facility computer system in I on which Resident #1 causing her to not do the MAR. The documentation in #5 administered as in Resident #1 on 12/6/	ewed on 1/21/18 at 9:38 AM. did not give Resident #1 two 00 PM and 8:10 PM on ated, "Something must have to make a time error on the	F 8		ditional	
	indicate Nurse #5 ad	entation on the MAR to ministered the as needed sident #1 on those days and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		345011	B. WING			C 01/22/2018	
	ROVIDER OR SUPPLIER	E/LEXI		STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292		017222010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	Continued From page	ge 5	F 84	12			
	Nurse #5 was not a her health.	vailable for an interview due to					
		in the CMUR indicated Nurse as needed dose of Norco to 9/17 at 4:00 AM.					
	indicate Nurse #6 a	mentation on the MAR to dministered the as needed esident #1 on 12/9/17 at 4:00					
	Nurse #6 stated she the MAR on 12/9/17 on accident. She sta	viewed on 1/22/18 at 5:38 AM. e had missed documenting on 7 at 4:00 AM for Resident #1 ated she definitely gave the maybe distracted and did not AR.					
	#7 administered as	in the CMUR indicated Nurse needed doses of Norco to 30/17 at 3:00 PM and 12/31/17					
	indicate Nurse #7 a	mentation on the MAR to dministered the doses of \$\foatin 12/30/17 at 3:00 PM and \$\lambda\$.					
	Nurse #7 stated the absolutely given to and administration t	riewed on 1/21/18 at 8:43 AM. medication Norco was Resident #1 on those dates times. Nurse #7 stated it was ion issue on her part.					
	PM. The DON state	viewed on 1/21/18 at 12:42 d her expectation was for the CMUR after giving a narcotic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345011	B. WING		01/22/2018	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI				STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	01/22/2016	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 842	Continued From pag	e 6	F 842	2		
	to a resident and as a narcotic was adminis	soon as possible sign the stered on the MAR.				
	I .	n order for one tablet of mg to be given by mouth eded.				
	Administration Recor	on the Controlled Medication rd (CMUR) indicated Nurse use of Oxycodone HCL to 18 at 3:00 AM.				
	Administration Recor	nentation on the Medication rd (MAR) to indicate Nurse use of Oxycodone HCL to 148 at 3:00 AM.				
	Nurse #5 was not avenue her health.	ailable for an interview due to				
	Nurse #7 administere	on the CMUR indicated ed a dose of Oxycodone HCL 13/18 at 9:00 PM, 1/14/18 at 8 at 10:00 PM.				
	indicate Nurse #7 ad	nentation on the MAR to ministered doses of Resident #2 on those dates				
	Nurse #7 stated the given to Resident #2	Nurse #7 stated it was likely				
	#8 administered dose	n the CMUR indicated Nurse es of Oxycodone HCL to 18 at 8:00 AM, 1/14/18 at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345011	B. WING				C / 22/2018
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI				STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292			22/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	2:00 PM, and 1/18/18 There was no docum indicate Nurse #8 add Oxycodone HCL to R and administration tir Nurse #8 was not intercontact information. The documentation on Nurse #4 administered to Resident #2 on 1/15:00 PM, 1/17/18 at 3 PM. There was no documentation of the contact information of the contact information.	entation on the MAR to ministered the doses of esident #2 on those dates nes. erviewed due to a lack of the CMUR indicated ed doses of Oxycodone HCL 5/18 at 3:30 PM, 1/16/18 at 3:00 PM and 1/17/18 at 7:00 entation on the MAR to	F	342			
	and administration tin Nurse #4 was intervie AM. Nurse #4 stated CMUR, then the med was given to Resider times. Nurse #4 state issues with the comp 2017 and the hall on was very busy causir administration on the The documentation or Nurse #9 administere to Resident #2 on 1/1 12:15 AM, 1/17/18 at PM, and 1/19/18 at 3	esident #2 on those dates nes. ewed on 1/22/18 at 10:30 that if she signed the ication Hydrocodone HCL at #2 on those dates and ad that the facility was having uter system in December which Resident #2 resided ag her to not document MAR. In the CMUR indicated ad doses of Oxycodone HCL 8/18 at 5:00 AM, 1/17/18 at 5:00 AM, 1/18/18 at 10:30 coo AM.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED	
		345011	B. WING			C / 22/2018
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI				STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	1 01/22/2010	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	and administration till Nurse #9 was intervi Nurse #9 stated she Oxycodone HCL to F CMUR. Nurse #9 state the MAR but on thos The documentation of Nurse #10 administe HCL to Resident #2 1/18/18 at 1:03 PM. There was no docum indicate Nurse #9 ad Oxycodone HCL on administration times. Nurse #9 was intervi PM. Nurse #9 stated doses of Oxycodone documented the adm (CMUR). She stated the administration tin it did not show she g The documentation of Nurse #3 administer to Resident #2 on 1/ There was no docum indicate Nurse #3 add indicate Nurse #3 a	Resident #2 on those dates mes. ewed on 1/22/18 at 5:20 AM. gave the doses of Resident #2 if it was on the sted she tried to document on e occasions she did not. On the CMUR indicated ared doses of Oxycodone on 1/17/18 at 9:15 AM and the entation on the MAR to ministered doses of those dates and ewed on 1/21/18 at 12:14 she did administer the HCL to Resident #2 if she hinistration on the Narc sheet that maybe she did not save me on the MAR and therefore ave the medication. On the CMUR indicated ed a dose of Oxycodone HCL 18/18 at 5:45 PM.	F 84			
	Nurse #3 stated she	ewed on 1/21/18 at 9:38 AM. gave the dose of Oxycodone if she documented it on the				

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F 842	CMUR. The Director of Nursin on 1/21/18 at 12:42 P expectation was for the company of the compa	ng (DON) was interviewed M. The DON stated her ne nurses to fill out the narcotic to a resident and as the narcotic was	F8	42		