PRINTED: 11/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		IPLE CONSTRUCTION	ON (X3) DATE SURVEY COMPLETED		
			A. BUR	A. BUILDING		(,	
•		345179	B. WIN	IG_			9/2011	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIAN CE	NTER HEALTH AND RE	TIREMENT	752 E CENTER AVE					
				MOORESVILLE, NC 28115				
(X4) ID			IO PREF		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO		DATE	
					DEFICIENCY)			
					T 246			
	483.25(d) NO CATHE		F	31				
SS=D	RESTORE BLADDEF	₹			1. Corrective action has			
		0			accomplished for the			
	Based on the residen				deficient practice in re	gards to		
	resident who enters the	ity must ensure that a			Resident #5 by provid			
		not catheterized unless the			with immediate training			
	•	dition demonstrates that			Director of Nursing re			
		ecessary; and a resident			provision of incontine			
		bladder receives appropriate			the proper techniques help prevent a UTI.	in order to		
	treatment and service	es to prevent urinary tract			training was complete			
		ore as much normal bladder			11 Upon notification of			
	function as possible.				the Director of Nursin	ni 11-2-11,		
			}		that proper incontinen			
	This DECUMENTAL	is not uset as ordeneed			provided to Resident #			
		is not met as evidenced			provided to resident h	ro.	12.7.11	
	by:	ns, record review and staff			2. Facility residents who	are	15.1.11	
		staff failed to provide			incontinent have the p			
		ng proper technique to			be affected by the sam			
		one (1) of two (2) sampled			deficient practice; ther			
	residents, (Resident	# 5).			Director of Nursing an	ıd/or Unit		
					Coordinators has com	oleted an		
	The findings are:				audit of current resider	nts to		
	A	d			identify those residents			
		procedure titled "Perineal Patient" from Lippincott,			incontinent. The Direct	ctor of		
		dated 10/08/2011 stated to			Nursing and /or Unit			
	1	ith one hand and wash with			Coordinators will cond			
		e downward strokes from			audit to identify any po			
		erineum to prevent intestinal	1		patterns of UTI's on or			
	organisms from conta	aminating the urethra or	1		7-11. Negative finding	g have been		
	vagina."				Preparation and/or execution of this pla	n of		
					correction does not constitute admission			
		nitted to the facility with			agreement by the provider of the truth of	f the facts		
	diagnoses including of		1		alleged or conclusions set forth in the st	atement of		
	pressure and a stroke	5 .			deficiencies. The plan of correction is p and/or executed solely because it is requ	repared tired by the		
	The quaderly Minimu	m Data Set (MDS) dated			provisions of federal and state law."	area oy me		
	1 4	2 2 (2.) 2 2						
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u>'</u>		TITLE		(X6) DATE	
					$\Lambda I = I I$		2/2/11	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegua de 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 following the date of survey whether or not a plan of correction is provided. For nursing nones, the above missing an approved plan of correction is requisite to continued 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.

Original Signature Date: 12-1-11 Event ID: UX8T11

Facility ID: 922988

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		c	
		345179	B. WNG_		11/09/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVE MOORESVILLE, NC 28115				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		JLD BE COMPLETION	
F 315	07/31/11 indicated in term memory and mo cognition for daily decrequired extensive as hygiene and bathing a incontinent of bladder. A review of a physicial stated to obtain a urinand culture and sensitivity results indicoli). A review of a physicial stated to obtain a urinand culture and sensitivity results indicoli). A review of a physicial stated urinary tract infection a urinary tract infection a urinary tract infection of two (2) plus bacterinesults with mulliple or gram negative rods. Order dated 11/08/11 250 milligrams orally for a urinary tract infections. During an observation 11/09/11 at 1:48 PM her back in her bed. washed her hands, president #5's brief wurine. NA #1 took a washed leansing professident #5's left (L)	pairment in short and long derate impairment in sision making. The resident sistance from staff for and was frequently. In sorder dated 08/28/11 the specimen for urinalysis tivity. A review of laboratory 1 revealed culture and cated Escherichia coli (E. hysician's order dated order for Macrobid 100 to daily for two (2) weeks for in. In sorder dated 11/07/11 culture and sensitivity to rule tion. A review of laboratory 1 revealed urinalysis results a and culture and sensitivity inganisms present including A review of a physician's revealed an order for Cipro twice daily for two (2) weeks ction. In of incontinence care on Resident # 5 was lying on Nursing Assistant (NA) #1 but on gloves and removed thich was saturated with reshcloth and wet it with a coduct (periwash). She pulled	F 318	corrected. The Adwill review the present Resident Concern Resident Council Management of Resident Council Management Of Resident Council Management Of Resident Council Management Of Resident Of	vious 6 mon hs ns and linutes to with This review or before 12-7- gs have been clace to ensure recient practice de: inservice staff by the and or Staff linator r technique re. CNAs will ing with n of learning revelopment orth Carolina N/LPN). completed on Care rounds t least three for 90 days er by the , Unit plan of sion or th of the facts te statement of is prepared required by the	

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		345179	8. WING _		11/09/2011
	OVIDER OR SUPPLIER INTER HEALTH AND RE	TIREMENT		REET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVE MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			OULD BE COMPLETION	
F 315	leg. NA #1 held Resi hand and with her off down (front to back a several strokes inside She discarded the first another one and wet pushed Resident #5's leg with one hand and up and down with several groin. NA #1 rinsed a inside each groin who forth with the periwas the resident, removed hands. During an interview of NA #1 she stated she up and down and she to make sure she got further stated she reacteaned the resident. During an interview of the Staff Development coordinated infection stated the facility profor incontinence care when they were hired with them annually, assistants were expepilicy during incontinus stated she was aware history of urinary trace. During an interview of the Director of Nurse her expectation for no	dent #5's left leg in one per hand, wiped up and had back to front) with a Resident #5's (L) groin. St washcloth and took it with periwash. She is (R) leg apart from the (L) if with her other hand, wiped veral strokes inside her (R) and dried Resident # 5's skin bere she had wiped back and had have and washed her in 11/09/11 at 2:15 PM with a thought it was okay to wipe a always wiped up and down the resident clean. She dized she should have more thoroughly. In 11/09/11 at 4:05 PM with a Coordinator who also control in the facility she wided orientation and training to the nursing assistants and it was reviewed again. She stated nursing cted to follow the facility ence care. She further a that Resident #5 had a	F 315	Coordinators and Development Coorvalidate appropria care techniques ar Negative finding simmediately correction 4. The Director of N Administrator will results of the roun Council meeting a a monthly basis, a for trends/patterns findings to the QA Committee. The Q Committee will m 4 weeks and then days and then at letter the effect plan, and based or outcomes, may an ensure continued of the correction does not constitute admagreement by the provider of the talleged or conclusions set forth in deficiencies. The plan of correction and/or executed solely because it is provisions of federal and state law	rdinator to te incontinence e being used. will be cted. ursing and/ or I review the ds, Resident nd Concerns on nalyze the data and report the &A AA AA eet weekly for monthly for 90 rast quarterly. nittee will iveness of the negative mend the plan to compliance. is plan of ission or ruth of the facts the statement of n is prepared s required by the

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		345179	B. WING			9/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT		STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVE MOORESVILLE, NC 28115					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 315	prevent infection and She also stated the n have wiped up and deduring incontinence of 483.65 INFECTION CSPREAD, LINENS The facility must esta Infection Control Programe, sanitary and control help prevent the deformation of disease and infection Control Fine facility must esta Program under which (1) Investigates, contributed in the facility; (2) Decides what program under which (3) Maintains a record actions related to infection determines that a resprevent the spread of isolate the resident. (2) The facility must program unicable disease from direct contact will transport to the spread of isolate the resident.	to follow the facility policy. Jursing assistant should not bown but from front to back are. CONTROL, PREVENT Delish and maintain an an area designed to provide a anfortable environment and evelopment and transmission con. Program colish an Infection Control it - Tols, and prevents infections are during a solution, an individual resident; and a for incidents and corrective citions. If of Infection are Control Program dent needs isolation to infection, the facility must be or infected skin lesions the residents or their food, if smit the disease.	F 315	F 441 1. Corrective action accomplished for deficient practice Residents # 4 and providing CNA # immediate trainin by the Staff Devel Coordinator regar of a safe, sanitary comfortable envir help prevent the diransmission of diinfection. Upon requipment potentic contaminated was the supervision of Nursing on 11-9-12. Facility residents assistance with Ac Daily Living (AD potential to be affisame alleged defice The Director of Nurser of the Preparation and/or execution of the same action of the same and the supervision of the Director of Nurser of Nur	the alleged in regards to # 5 by 1 and # 2 wit g on 11-15-1 lopment ding provisio and onment and to evelopment a sease and ottification, the ally cleaned under the Director 11. who receive ctivities of Ls) have the ected by this cient practice tursing, Unit	n 12.7. N n nd ne ar of	
		equire staff to wash their ct resident contact for which ated by accepted		correction does not constitute adn agreement by the provider of the alleged or conclusions set forth in deficiencies. The plan of correction and/or executed solely because it provisions of federal and state law	nission or truth of the facts the statement of on is prepared is required by the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345179	B. WING	3		i	9/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT			STREET ADDRESS, CITY, STAT 752 E CENTER AVE MOORESVILLE, NC 28					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPI			(X5) COMPLETION DATE	
F 441	infection. This REQUIREMENT by: Based on observation interviews the facility contaminated gloves two (2) of two (2) same 4 and # 5). The findings are: 1. Resident # 4 was a diagnoses including diagnoses and a history. The annual Minimum 07/24/11 indicated imperorung and diagnose as hygiene and bathing a of bladder and bowel. During an observation 11/09/11 at 11:15 AM was observed to was gloves. She bathed Residual in the second secon	is not met as evidenced is not met as evidenced is, record review and staff staff failed to remove after incontinence care for pled residents. (Resident # admitted to the facility with ementia, high blood of urinary tract infections. Data Set (MDS) dated pairment in short and long derate impairment in ision making. The resident sistance from staff for and was always incontinent of incontinence care on Nursing Assistant (NA) #2 in her hands and put on resident #4 and opened the	F	Coord Devel condu reside with A compl 3. Meas that th does r for nu Devel Direct provis comfo help p transn infecti and gl after i trainin before be con times j weekl of Nur and or Coord approp	dinator and/or Stopment Coordinate an audit to idents receiving as ADLs. This actileted on or before alleged deficing the alleged deficing the alleged deficing staff by the opment Coordinator of Nursing resion of a safe, satisfaction of disease on to include his overchanges duration of disease on to include his overchanges durationent care. In well a least the per week for 90 y thereafter by the staff Developminator to validatoriate infection of ques are being under the staff of th	nator will lentify sistance ion will be re 12-7-11. The recto ensurent practice: Inservice e Staff nator or regarding the nitary and nent and to lopment and to lopment and ring and This leted on or rounds will three (3) days and he Director dinators nent e control ised.	e /2.7.1\ d	
resident's brief that was saturated with urine. She provided incontinence care and put a clean brief on Resident #4. She picked up clean clothes and dressed Resident #4 still with the same gloves on and picked up the call light and fastened it to Resident #4's bed. She then removed her gloves			correction does not agreement by the pr alleged or conclusion deficiencies. The pl and/or executed sol- provisions of federa	constitute admission rovider of the truth of the truth of the same of correction is perfect to the content of the correction is perfect to the content of th	n or of the facts tatement of orepared			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		345179	B. WING				11/09/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT		TIREMENT	:	STREET ADDRESS, CITY, STATE, ZIF 752 E CENTER AVE MOORESVILLE, NC 28115	CODE			
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a ENR Conhire a Ett conhire a	IA #2 she stated she desident #4's clean contaminated gloves have removed them a noonlinence care and nything else. During an interview of the Staff Development oordinated infection tated nursing assistancent incontinence care and lean items in the resolves on. During an interview of the Director of Nurses er expectation nursing er expectation nursing er expectation nursing in a resident's resolves in a resident's resolves in a resident's resolves after incontent in a resident's resolves and a stroke the quarterly Minimum (7/31/11 indicated imperm memory and motognition for daily decontent in the resolves and a stroke the quarterly Minimum (7/31/11 indicated imperm memory and motognition for daily decontent in the content in the resolves in the quarterly Minimum (7/31/11 indicated imperm memory and motognition for daily decontent in the resolves in the quarterly Minimum (7/31/11 indicated imperm memory and motognition for daily decontent in the resolves in the quarterly Minimum (7/31/11 indicated imperm memory and motognition for daily decontent in the resolves in the	In 11/09/11 at 11:28 AM with realized she touched lothes and call light with on. She stated she should after she finished the dibefore she touched In 11/09/11 at 4:05 PM with at Coordinator who also control in the facility she and were taught to remove a their hands after providing dithey should not touch any ident's room with their soiled in 11/09/11 at 4:15 PM with a (DON) she stated it was ang assistants should change antinence care. She stated andle clean linens or other coom with soiled gloves on. Idmitted to the facility with diabetes, high blood and the compariment in short and long derate impairment in sistence from staff for and was frequently	F 4	4. The Direct Administ results of Council results of Council results of trends findings to Committe will meet inouthly least Qual Committe effectives based on amend the	finding will tely corrected to of Nurserator will refer the rounds meeting and by basis, and so the QA& ee. QA&A weekly for for 90 days rerly. The ee will evalues of the progrative or e plan to end I compliant of the truth set forth in the of correction is because it is not because	sing and/or eview the , Resident il Concerns lyze the da nd report the A Committee and then are e QA&A uate the plan, and atcomes, mand atcomes, atcomes, atcomes, atcomes, atcomes, atcomes, atcomes, atcomes, atcomes, atc	on a e 12.7.11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILOIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345179 B. WNG			С		
NAME OF PR	ROVIDER OR SUPPLIER	040170			11/0	9/2011
BRIAN CENTER HEALTH AND RETIREMENT		1	REET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVE MOORESVILLE, NC 28115		į	
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F 441	11/09/11 at 1:48 PM I washed her hands, pure Resident #5's brief that She removed her glow cleaning Resident #5 She put a clean brief to put Resident #5's puthem off and put them to Resident #5's clother gloves on and picked to find clean pants for clean pants on Reside gloves on and covered then removed her glow During an interview or NA #1 she started to puput them in a plastic bestated she thought the and she should have a she touched any of the #5's closet. During an interview or the Staff Development coordinated infection of stated nursing assistat their gloves and wash incontinence care and	of incontinence care on Nursing Assistant (NA) #1 at on gloves and removed at was saturated with urine.	F 441	DEFICIENCY)		12.7.{(
	the Director of Nurses her expectation nursin	11/09/11 at 4:15 PM with (DON) she stated it was g assistants should change attinence care. She stated				

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND RETIREMENT				STREET ADDRESS, CITY, STATE, ZIP COD 752 E CENTER AVE MOORESVILLE, NC 28115		09/2011	
(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 C	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	they should never ha	e 7 Indie clean linens or other room with soiled gloves on.	F 4			/2.7.11	